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Practice and Practitioner Correlates of Psychotherapists' Self-Perceived Clinical Wisdom

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PRACTICE AND PRACTITIONER CORRELATES OF PSYCHOTHERAPISTS' SELF-PERCEIVED CLINICAL WISDOM

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Wisdom is seen as quality that makes the navigation of the complex issues of human existence easier. A role that wise individuals often perform is that of problem-solver, advisor, and mentor. Therapist factors have been found to account for a greater role in treatment effectiveness than the choice of treatment modality; therefore, this study attempts to find parallels between the fields of psychotherapy research (therapist factors) and self-perceived wisdom by examining the practice and practitioner correlates of therapists who feel wise with their clients.

This study analyzed data collected over the past two decades by members of the Society for Psychotherapy Research Collaborative Research Network (SPR/CRN) using the Development of Psychotherapists Common Core Questionnaire (DPCCQ). Statistical analysis using correlations and ANOVAs was completed to compare the practice and practitioner correlates of 4139 therapists, who marked themselves as Very Wise, Much Wise, Somewhat Wise, and Not at All Wise on the DPCCQ. Practice variables that were significantly associated with high, self-perceived clinical wisdom included higher levels of clinical skills, lower levels of difficulties in practice, and higher levels of constructive and reflective coping in response to these difficulties.

The Very Much Wise therapists held the therapeutic frame more flexibly, felt significantly less anxious, were more inspired and stimulated, and were more available in sessions. Feeling Wise with clients was not related to the sex of the therapist but was related to the therapist's age, with older therapists feeling Much Wiser than younger therapists. Therapists'

self-perceived clinical wisdom was significantly positively correlated with how Wise they felt they were in their close, intimate relationships. Lastly, therapists who felt Very Much Wise with their clients had significantly higher levels of current life satisfaction, significantly lower life stress, and significantly higher emotional and psychological well-being. Conclusions are discussed to give directions and suggestions for future professional development of psychotherapists.

CHAPTER ONE

INTRODUCTION

The search for wisdom is timeless and found in all cultures. Societies from all parts of the world have representatives in their communities providing wise counsel. In modern western society, psychotherapists are the secular ministers and shamans that assist in the pursuit of answering life's most challenging personal questions. Wise people are generally considered to possess the ability to lead, guide, or teach (Karelitz, Jarvin, & Sternberg, 2010, p. 850), and therapists are seen to engage in the dispense wisdom—a quality considered rare and socially valued. But do therapists themselves feel wise when working with their clients? If so, what features of therapeutic work characterize their sense of wisdom in practice? Who are these therapists and what distinguishes them from others who do not see themselves as wise? This study attempts to answer these questions by exploring the practice and professional characteristics of psychotherapists who perceive themselves as wise when working with clients.

Background of the Problem

The impact of the therapist on the practice of psychotherapy has been researched and proven in many studies. Therapist variables, especially differences among therapists, are critical to understanding the therapeutic alliance and therefore the client. Therapist factors examined in past research (in relation to outcomes) includes personality factors, interpersonal capacities, and self-perception of work and personal life, (Heinonen, Lindfors, Laaksonen, & Knekt, 2012; Nissen-Lie, Monsen, & Rønnestad, 2010; Zeeck et al., 2012).

The interplay of personality factors, interpersonal skills, and wisdom of the therapist affects the work of therapy significantly more than was thought in some previous research. The conclusion of initial studies on skills and specific therapy techniques (Hill, 2004; Truax & Carkhuff, 1967) demonstrated that while skills and techniques are valuable, they don't fully explain what works in therapy (Lambert, 1992; Wampold, 2001). Research has shown that therapist variables account for a greater role in treatment effectiveness than the treatment modality (Wampold, 2001; Wampold & Brown, 2005). In addition, a positive therapeutic alliance has been the single consistent factor associated with a positive outcome of therapy (Baldwin, Wampold, & Imel, 2007; Norcross & Wampold, 2011; Orlinsky, Rønnestad, & Willutzki, 2004). Consequently, research on the therapeutic alliance has dominated much of the field of psychotherapy research for the past two decades (Falkenström, Granström, & Holmqvist, 2013; Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012; Safran & Muran, 2000). Certain traits (relationship factors) of therapists facilitate the therapeutic alliance and help move the work of psychotherapy forward. The traits associated with wisdom in counselors cause a significant variability in the therapeutic alliance (Osterlund, 2011). Orlinsky, Schofield, Schröder, and Kazantis (2011) concluded that both the task-instrumental and the relational aspects of therapeutic process expected from a therapist are at a very high level, even more so than in their close personal relationships. What is not clear is whether the task-instrumental and the interpersonal aspects of practice are associated with the self- perception of being wise.

Wisdom is not a unidimensional construct, but a set of factors that come together to approximate attributes such as *expertise* or *mastery* of the problem solving or guiding domain. When therapists excel at what they do, their colleagues may consider them as experts or master

therapists by knowing them as supervisors, as their own personal therapists, or through the results achieved with clients known to them (e.g., persons referred by them as clients). They are seen as therapists who perform at an exceptional level consistently, which means the majority of clients would experience similar positive outcomes with the same therapists (Crits-Cristoph et al., 1991; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997; Wampold & Brown, 2005). Psychotherapy researchers have designed studies to differentiate exceptional therapists from others and found that master therapists have exceptional cognitive, emotional, and relational characteristics similar to the personal qualities attributed to wise people (Ardelt, 2004; Bluck & Glück, 2005). For example, wise people and master therapists have both been found to demonstrate cognitive complexity, reflectiveness, an ability to embrace uncertainty and ambiguity, self-awareness, nondefensiveness, and strong relationship skills (Rønnestad & Skovholt, 2013).

Therapists were found to possess a heightened version of the personal qualities ascribed to wise people in the general public; for example, a special ability to understand other people, taking the longer view on situations, reading between the lines, demonstrating empathy and concern for others, and showing skill in dealing with uncertainty (Clayton & Birren, 1980; Sternberg, 1990). Wisdom has also been associated with emotional maturity; affective complexity (Labouvie-Vief & Medler, 2002); reflection (Clayton & Birren, 1980); and exceptional understanding, judgment, and communication skills (Holliday & Chandler, 1986). Research on wisdom indicates that these dimensions, when taken together, define the strong, positively valued interpersonal skills of wise people.

Most of these qualities pertaining to being wise can be classified under the dimensions of reflective, affective, and cognitive traits (Ardelt, 2000; Bluck & Glück, 2005), which is similar to the classification of the qualities of master therapists (Jennings et al., 2008; Rønnestad & Skovholt, 2013). Recent psychotherapy research parallels the study of wisdom in gravitating toward the study of the characteristics of the person of the therapist—especially their interpersonal skills (Anderson, McClintock, Himawan, Song, & Patterson, 2016; Schöttke, 2016). Therapists' personality and interpersonal skills are predictors of alliance and outcome and thus, are a source of therapist effects in research. Included under the domain of interpersonal skills by some researchers are elements of empathy, other-focus, and affective self-regulation (Wampold, 2010).

Human problems, by their very nature, are often complex and multifaceted. A good therapist must take into account the complex factors affecting each person (client) and his or her environment. This environment is dynamic, rapidly changing, and increasingly global with social structures evolving in complexity (Kramer, 2000). Each client requires the therapist to embrace a new understanding, mode of thinking, and dialectic. Consequently, the therapist's mode of thinking must possess the flexibility to encompass change and apparent contradiction that can adapt to clients' changing experiences.

This study focuses on the skills and qualities of therapists that help them navigate the complexity of psychotherapy wisely. The ability to be empathic and comfortable with ambiguity makes therapists intriguing subjects for study by wisdom researchers and therapy researchers alike. Therapists tend to perform better on tasks assessing wisdom and on self-reports of being wise, as compared to those not in the helping profession (Wink & Helson, 1997). Staudinger,

Maciel, Smith, and Baltes (1998) suggested that the reason therapists' performed well on tasks measuring wisdom had to do with their professional training:

> Individuals who by virtue of their profession (e.g., clinical psychology) receive training, guided practice (mentorship), and massed experience in fundamental issues of life and the human condition, accumulate higher levels of wisdom-related knowledge compared to individuals without access to this type of experiential setting. (p. 14)

Although training and experience were defined according to the therapists' specific professional training and not personal experience, it seems likely that persons attracted to the profession already possess a basic capacity for the development of wisdom-related qualities.

The implications drawn from wisdom literature suggest that wise therapists would have developed the cognitive complexity to contextualize treatment, the reflective ability to understand the language of symptoms, and the affective elements of empathy to engage in meaningful therapeutic alliances with their clients; and at significantly higher levels. The attributes of cognitive complexity, reflective skills, and exceptional relational skills would influence not only the practice of the self-perceived wise therapist but also who he or she is as a person. Very few researchers have tried to bridge these two fields of inquiry (i.e., wisdom and psychotherapy) to empirically study the nature of wisdom therapists seem to possess. This study attempts to empirically explore these ideas by looking at the practices therapists relate to being wise with clients and the professional and practice correlates associated with high-levels of self-perceived wisdom in psychotherapists.

The sample for this study is drawn from the decades-long, multinational study conducted by the Society for Psychotherapy Research Collaborative Research Network (SPR/CRN) using the Development of Psychotherapists Common Core Questionnaire or DPCCQ (Orlinsky et al.,

1999). This self-report survey instrument provides rich cross-sectional data on professional and personal variables associated with the development of psychotherapists. The large dataset has been collected over the years by the CRN researchers, from which a subsample was drawn based on the number of therapists who answered a question related to Feeling Wise with clients. This subset was analyzed to explore the following research questions:

I. What differentially characterizes *therapeutic practice* for therapists who see themselves as *more* or *less* wise with clients? Drawing on information collected with the DPCCQ, the two aspects of practice examined are:

   A. Technical-instrumental aspects of practice

      1. treatment goals (aims of practice)
      2. clinical skills (implementation of aims)
      3. difficulties in practice (difficulties encountered in implementation of aims)
      4. coping strategies (strategies for coping with difficulties in practice)

   B. Interpersonal-affective aspects of practice

      1. frame and boundary management (norms and limits of the therapist role)
      2. relational manner (style of relating to clients)
      3. therapist's feelings in the therapy session (therapist's personal affects regarding clients *within-session*)
      4. therapists' inter-session experiences about patients (therapist's thoughts and affects regarding clients *between-sessions*)

II. What are the distinguishing characteristics of therapists who perceive themselves as being Wisest with clients? Therapist characteristics described in the DPCCQ include:

A. Professional characteristics

    1. career level (years in practice)
    2. experienced career development to date
    3. professional identity
    4. theoretical orientation
    5. training and supervision
    6. personal therapy (utilization and experienced benefit)
    7. experienced current development

B. Personal characteristics

    1. wisdom in close personal relationships
    2. therapist age and sex
    3. therapist marital and parental status
    4. therapist quality of life (positive and negative) and emotional well-being
    5. nationality

CHAPTER TWO

REVIEW OF THE LITERATURE

To understand clinical wisdom and its relationship to therapist factors in psychotherapy, it is important to first review the current state of empirical research in the general field of wisdom.

How is Wisdom Defined and Measured?

The definition of wisdom has resisted consensus among both the general public and researchers, remaining among the most complex characteristics of people and societies through history (Birren & Svensson, 2005). Several complexities contribute to that difficulty. One key complexity relates to which theoretical orientation guides the investigation—as researchers in philosophy and theology, management and organization studies, psychology, and the liberal arts have studied the topic and developed tools and measures. Another difficulty in wisdom research involves realizing that what has been considered wise today may or may not be considered wise in another era or from a subjective perspective. For example, the definition of wisdom by a 20-year-old Caucasian woman living in an urban area might differ greatly from the definition of wisdom by an 85-year-old Chinese man living in a rural area. Research on wisdom is also confounded because a popular belief that wisdom is commonly seen in people contrasts sharply with researchers who see wisdom as a rare attribute in the general population. The researchers who view wisdom as rare believe it is unusual for all the variables (affective, reflective, and cognitive) to come together often in a person. The mere presence of these variables in isolation is

not enough—these variables have to synchronize, integrate, or orchestrate together in ways that cannot be predetermined. This spontaneous yet consistent orchestration makes wisdom a rare attribute in people. A final complexity involves the philosophical question whether wisdom can exist if not perceived by another. Similar to other valued traits—love, goodness, beauty—wisdom has been considered contextual and defined by the other.

Despite these difficulties and disagreements, there has been convergence on understanding what wisdom is or who is wise (Baltes & Staudinger, 2000). Lyster (1996) compared wisdom assessed by quantitative methods with global impressions of wisdom as assessed by raters. She concluded there is a distinct and perceptible quality of wisdom, which can be identified reliably and captured by some of the existing measures of wisdom (Lyster, 1996).

The social context of wisdom was found to manifest in an ability to give advice with tact, listen well and skillfully, and guide in a manner that preserves the relationship (Montgomery, Barber, & McKee, 2002). A person or the act is judged wise by society if it is perceived as a balance between the needs of the individual and the community (Sternberg, 1998). Wisdom represents a consensual reality, agreed upon by most people; it is not an objective criterion of truth (Habermas, 1970). A number of studies have shown that laypersons have relatively consistent ideas about what constitutes wisdom (Bluck & Glück, 2005; Clayton & Birren, 1980; Holliday & Chandler, 1986). These include insight, intuition, reflective attitude, common sense, empathy (concern for others), and high-levels of cognitive abilities. Wisdom is easily recognized even though it is difficult to describe, define, and achieve (Staudinger, Dörner, & Mickler, 2005). In a similar manner, Ardelt (2005) compared attempting to define wisdom to the case of blind

men and the elephant. In the story of blind men and the elephant, each person believed that the part of the animal's body he or she touched was the true object or animal. For example, the blind men who touched the elephant trunk thought the elephant was similar to a snake. The ones who felt the elephant ears thought the elephant was similar to a fan. The blind men who felt the tail thought the elephant was similar to a rope. The blind men could not be dissuaded that there was more to the elephant than the part they were touching. In the case of wisdom, unlike the case of the elephant, the effect is cumulative. These components all add up, leading to a better understanding of wisdom. However, researchers are not yet at a point where they have a complete and coherent picture. It is possible, and perhaps likely, that the whole is other than or greater than the sum of its parts (Anderson, Carter, & Lowe, 1999; Koffka, 1935).

Components of Wisdom

Since the 1970s, five areas of psychological wisdom research have been established in academic circles including providing a layman definition of wisdom, conceptualizing and measuring wisdom, understanding the development of wisdom, investigating the plasticity of wisdom, and the applying psychological knowledge about wisdom in real life contexts (Staudinger & Glück, 2011). From a relatively forgotten area in the 1970s, the wisdom field has grown "to become a promising dark horse in adult development's stable of new constructs" (Chandler & Holliday, 1990, p. 128). A large number of studies with increasing sophisticated methods and research designs have attempted to grasp this concept of wisdom.

This section discusses the components of wisdom and details the manner in which the psychology field *rediscovered* wisdom. Section A summarizes research on individuals' intrinsic theories regarding wisdom—implicit theories. These studies were designed to understand the

various ideas about wisdom that ordinary people carry in their heads (also known as *folk theories* of wisdom. Section B summarizes research that attempted to make explicit or operationalize the components of wisdom. The purpose of these studies involved constructing a scientific theory of wisdom by explicating the relationship between components of wisdom and how they come together for a wise output.

Section A—Implicit Theories of Wisdom

This section has been organized according to the methods used by various researchers to study wisdom. It begins by looking at the results of studies that brought to light components of wisdom using a descriptor rating method. These are followed by studies using a phenomenological approach and an autobiographical approach. Finally, study results using a nomination method are reported.

A large number of studies that studied the components of wisdom from an implicit perspective used *descriptor-rating methods* (Bluck & Glück, 2005). First, participants generate lists of attributes they associate with wisdom. These lists are then merged to create a master list eliminating redundancies. As a second step, this master list gets presented to another group of participants who then rate each term for its centrality to the concept of wisdom. This method was used by early researchers in the wisdom research field from 1975-1985. Clayton's (1976) use of this method opened the wisdom field to psychological inquiry. In her research, she asked participants from different age groups to describe a wise person. The generated lists of attributes are presented to the participants again so that they can rate how similar the adjectives generated were to the attributes they perceived in wise people, senior adults, and their own selves. Three components of wisdom emerged from the multidimensional scaling analysis, namely: *affective,*

reflective, and *cognitive*. Clayton and Birren (1980) found that most implicit theories of wisdom consist of an integration of these three components—a truth borne out by studies to date.

Holliday and Chandler (1986) used a different version of the descriptor rating method to study implicit wisdom. In their study, participants were asked to list attributes of people who are wise, shrewd, perceptive, intelligent, and foolish. This was followed by a separate group of participants who were asked to rate these attributes on how well they describe a wise person. Five factors emerged from these studies, which were seen as typical of wise people:

1. Exceptional understanding.
2. Sound judgment and communication skills.
3. General competence (e.g., curiosity, intelligence, thoughtfulness).
4. Good interpersonal skills.
5. Social unobtrusiveness. (Holliday & Chandler, 1986)

Hershey and Farrell (1997) asked participants to rate a list of adjectives and occupations on a scale of Very Wise to Very Unwise. They found that study participants associated wisdom with professions requiring significant amounts of education (e.g., a doctor) or provided a higher social status (e.g., the president of the United States). The attributes associated with wise people consisted of making perceptive judgments and having a quiet, reflective nature. Jason et al. (2001) asked students in a Midwestern psychology program to name the wisest person they knew and rate their qualities. Two categories (categorized by judges) emerged: (a) drive/tenacity/ leadership and (b) insight/spirituality. Factor analysis of the scale items revealed five factors associated with wise people: harmony, warmth, intelligence, connecting to nature, and spirituality. Most research concluded that intelligence and wisdom seem highly correlated in

people's implicit theories (Sternberg, 1985, 1990). Bluck and Glück (2005) reviewed and synthesized the studies on implicit components of wisdom and concluded that the categories and attributes of most implicit studies of wisdom actually contribute to just five distinct areas: (a) cognitive ability, (b) insight (c) reflective attitude (d) concern for others, and (e) real-world problem-solving skills (i.e., application of knowledge and judgment to solve real-life problems for others and oneself).

In addition to descriptor rating methods, researchers used phenomenological methods to unearth the theories people hold about wisdom. Montgomery et al. (2002) conducted interviews with six individuals whose background was considered *wisdom-facilitative*. Wisdom-facilitative is a term referring to a background or professional activity in the field of pastoral counseling, teaching, or positions of civic leadership (Baltes & Staudinger, 1993). It was assumed that a background in these professional activities would enhance the development of wisdom. The six study participants with a wisdom-facilitative background were asked two questions: (a) Can you describe one or more times in your life in which you believe you were wise or acted wisely and (b) Can you describe a wise person in your life?

Results of this phenomenological study showed the quality of *guidance* was an important part of wisdom. Guidance involves showing a way to others through knowledge, experience, moral principles, and compassionate relationships. An interesting conclusion of this study involved the result of wise actions. The study participants reported that satisfaction from wise choices was derived over time and that often, the wisdom of a wise decision (wise choice) was only revealed after a passage of time.

Glück, Bluck, Baron, and McAdams (2005) used an autobiographical approach to determine aspects of wisdom related to age. In their first study, they compared the wisdom of adolescents and young and older adults. They found empathy and support, self-determination and assertion, and balance and flexibility to be associated with wisdom—although the frequency of these attributes differed with age. A second study compared the autobiographical narratives of middle-aged and older adults. Glück et al. found that most findings replicated the first study. In addition, the researchers found wisdom to be associated with empathy and support—irrespective of age.

What emerges from this summary of implicit theories is that wisdom involves a set of personality dispositions used in real-world social situations for helping others and for the use of the individuals themselves. The ability to lead, guide, or teach also seems to be commonly associated with wise people. Baltes and Staudinger (2000) summarized the results of research on implicit theories:

> Wisdom involves (a) possessing a specific, culturally-shared meaning, (b) reflecting an exceptional level of human functioning, (c) including cognitive, affective, and motivational aspects that are well-integrated, (d) reflecting high personal and interpersonal competence, and (e) involves good intentions. (p. 125)

A critical observation of the studies of implicit theories support an earlier observation: wisdom differs from person to person. People's views on wisdom are contextualized and contingent on their personal qualities and attributes (Karelitz, Jarvin, & Sternberg, 2010). Wisdom, in this sense, is ascribed by the other, rather than a proven quality that can be objectively identified (Meacham, 1990). This difference is seen in nomination studies where subjects are asked to name people they see as wise. Differences arise depending on the age of the

respondent (Clayton & Birren, 1980; Heckhausen, Dixon, & Baltes, 1989), gender (Denney, Dew, & Kroupa, 1995; Orwoll & Perlmutter, 1990), culture (Takahashi & Overton, 2005), professions (Sternberg, 1985), and spiritual beliefs (Hershey & Farrell, 1997; Jason et al., 2001).

One drawback to research tries to define wisdom by asking people's perception of what constitutes wisdom involves the high dependence on verbal behavior or language. There may be some behaviors not well-captured in language, either because these behaviors are implicit and hidden even to the perceiver or because the language does not lend itself to a true description or explanation of the attribute. Consequently, these may not get identified as much or not at all. Another problem with this type of research involves the attempt to construct an ideal wise person. The debate remains on whether such an ideal wise person can exist (Ardelt, 2004; Baltes & Kunzmann, 2004).

Table 1 lists a summary of the components that emerged from wisdom research examining implicit theories perspective.

Table 1. Summary of the Components of Wisdom Based on People's Implicit Theories

Year	Researcher	Components
1976 1980	Clayton Clayton & Birren	• Reflective (introspective, intuitive) • Cognitive (knowledgeable, experienced, pragmatic, observant, intelligent) • Affective (compassion, empathy)
1985	Sternberg	• Reasoning ability • Perspicacity • Learning from ideas and environment • Sagacity • Sensible judgments • Expeditious use of information
1986	Holliday & Chandler	• Exceptional understanding (self and others) • Sound judgment and communication skills • General competence (curiosity, thoughtfulness, intelligence) • Proper interpersonal skills • Social adeptness • Intuitive and moral
1997	Hershey & Farrell	• Basic temperament: withdrawn, quiet, reflective • Nonegotism: not demanding, arrogant or commanding • Make perceptive judgments
1999	Oser, Schenker, & Spychiger	• Solidarity • Situated intelligence • Calculated risk taking
2001	Jason et al.	• Intelligence • Warmth (humor, kindness, compassion)
2002	Montgomery, et al.	• Guidance • Experience • Moral principles (good in all sense; willing to take a moral standpoint; integrity) • Time (the meaning of wise actions and behaviors was revealed over time/ understood over time) • Compassionate relationships
2005	Glück et al.	• Empathy and support • Self-determination and assertion • Knowledge • Flexibility
2005	Bluck & Glück	• Cognitive ability • Insight

		• Reflective attitude • Concern for others • Real-world skills
2013	Glück & Bluck	• Mastery • Openness • Reflectivity • Emotional regulation and empathy
	OTHER CULTURES/ETHNIC POPULATIONS	
1999	Levitt (Tibetan Buddhist monks)	• Good judgment • Self-examination • Efficient conduct • Compassion • Honesty • Humility • Respect • Genuine acts to meet the needs of others

2000	Takahashi & Bordia (Compared implicit wisdom theories of Eastern and Western participants)	• Western:
		  ○ Experienced and knowledgeable
		• Eastern:
		  ○ Discreet
		  ○ Aged and experienced

2001	Yang (Taiwanese Chinese)	• Competencies and knowledge • Benevolence and compassion • Openness and profundity • Modesty and unobtrusiveness
2002	Takayama (Japanese men and women)	• Knowledge and education • Understanding and judgment • Sociability • Interpersonal relationships • Introspective attitude

Section B—Explicit Theories of Wisdom

Another way researchers have studied wisdom involves constructing theories to understand how wisdom is manifested in various situations (and people). These theories are developed by researchers on the structure and/or characteristics of wisdom-related thinking,

action, and knowledge, rather than aggregating the perceptions of people about wise people or wise processes (Baltes & Smith, 1990; Baltes & Staudinger, 2000). Explicit theories focus on wisdom as a *pattern* of personality characteristics or type of problem-solving behavior. As a *process*, wisdom could be a typical characteristic in adult thought. By moving away from research examining attributes of wisdom as perceived by the general public, these explicit theories propose that particular cognitive, motivational, and affective components exist that need to coalesce in a person to facilitate the development of wisdom.

Some of these psychological theories of wisdom are examined in the following order:

1. Epistemic model
2. Organismic model
3. Tripartite model
4. Berlin wisdom model
5. Balance model of wisdom.

Brugman (2000, 2006) defined wisdom as expertise in uncertainty, which involves metacognitive, affective, and behavioral components, leading to the good life. His *epistemic model* highlighted an attitude toward knowledge and living rather than delineating separate components of wisdom. Brugman believed that wisdom is associated with increasing doubt about the comprehensibility of reality. Acceptance of the uncertainty of life, paradoxically, leads to emotional stability, which translates into dealing effectively with situations requiring flexibility. Brugman's model adds to the understanding of wisdom by looking at it as a *metacognitive variable*, similar to reflective or relativistic thought.

Kramer (1990) based his psychological model of wisdom on the observation that wise people seem to be better able to utilize their emotional experiences to grow and strive toward well-being. This *organismic model* is useful to understand wisdom as it emphasizes the dynamic connection of emotional intelligence to wisdom (Barrett & Salovey, 2002; Sternberg, 2001). Wisdom-related-growth, as seen by Kramer (1990), is characterized by a greater integration of feelings, behavior, and thought. The precursors to this growth are the awareness of one's subjectivity and the development of relativistic and dialectical thinking. According to Kramer, the "Integration of the affective, behavioral, and cognitive, aided by relativistic and dialectical thinking is conducive to exceptional insight and judgment about important life issues and situations" (p. 95). Kramer proposed that "Relativistic and dialectical thinking facilitates wisdom in five ways: (a) by recognizing individuality; (b) by taking context into account; (c) by fostering cooperative, empathetic strategies for interpersonal interaction; (d) recognizing possibilities for change; and (e) recognizing the necessity of integrating cognition and affect" (p. 300). Orwell and Perlmutter (1990) stated that when "empathy, understanding, and caring combine with dialectical thinking, people are capable of penetrating interpersonal insight and discernment" (p. 164). Hanna, Bemak, and Chung (1999) noted that it is precisely this type of penetrating personal insight that Sternberg (1990) referred to in his model of wisdom.

Integrating emotions with cognition is also evident in the *tripartite model* proposed by Ardelt (2003, 2004). She saw wisdom as the integration of the domains of *cognition*, *affect*, and *reflection*—which would be visible in the personality of the individual. Consequently, she does not see wisdom as an independent product such as a judgment, book, or wise decision, as seen by the Berlin model of wisdom proposed by the Berlin group of researchers. Ardelt (2004) defines

wisdom as a quality or characteristic of people. Ardelt's model highlighted aspects of cognition, which included a desire to know truth, understand the limits of knowledge, and accept the uncertainty of life. The affective domain captured personality characteristics of empathy and compassion for others while a reflective domain was related to insight and self-examination to overcome one's blind spots. Ardelt's model is similar to the model proposed by Birren and Fisher (1990), who said:

> Wisdom is the integration of the affective, conative (motivational) and cognitive aspects of human abilities in response to life's tasks and problems. Wisdom is a balance between the opposing valences of intense emotion and detachment; action and inaction; and knowledge and doubts. (p. 326)

Ardelt (2003, 2004) further highlighted dialectical thinking as the crux of wisdom. Likewise, the ability to think about multiple perspectives and reconcile seemingly opposing views of reality represents an important aspect of wisdom in psychotherapy (Hanna & Ottens, 1995).

The two most sophisticated and intricate models of understanding the nature of wisdom come from the following:

1. Berlin wisdom model proposed by Berlin group of researchers
2. Robert Sternberg (known more for his work on theories of intelligence and creativity)

Both theories have put forward models explaining the factors in the incubation and development in shaping wisdom. Robert Sternberg (1998) and the Berlin group of researchers also put forward criteria for examining expressions of wisdom. These models, while theoretically complex, have certain problematic assumptions and limitations.

The *Berlin wisdom model* was developed by Paul Baltes and his colleagues (1990-2006) at the Max Planck Institute in Berlin. It represents the most researched and often cited theory in the wisdom field. Unlike other earlier theories, these researchers sought to investigate the *performance* of wisdom rather than the attributes of a wise person. The Berlin group of researchers viewed wisdom as *expertise in the conduct and meaning of life*. They introduced the concept of fundamental pragmatics of life defined as the knowledge and judgment about the basic elements of the human condition and ways to plan, manage, and lead a good life. Central to this knowledge was an understanding of the following:

1. Social-contextual factors of the person.
2. Knowledge about oneself and others.
3. Finiteness of human life.
4. Appreciation of the spiritual dimensions of life, such as mind-body dynamics and the existence of God or divinity.

These elements are important clinically as they inform the fundamental pragmatics of doing psychotherapy; for example, an understanding of the developmental history of the client, how that history is understood by the therapist in light of the developmental history of the therapist, the understanding that at no point does the therapist have a complete understanding of the client's problem, and a willingness to accept the limits of one's knowledge. These elements of clinical wisdom would inform the clinical practice of a therapist by making it more reflective, introducing cognitive complexity, and making the affective component very dynamic (Hanna et al., 1999).

In the Berlin wisdom model proposed by Berlin group of researchers, wisdom or wise performance had certain antecedent factors. These included (a) general personal factors (cognitive styles, ego strength, openness to experience), (b) specific expertise factors (motivational dispositions like generativity or generosity, experience in life matters), and (c) facilitative experiential contexts such as age, education, profession, parenthood, and providing mentorship. Baltes and Smith (1990) summarized their findings by emphasizing the personal disposition and the ability to integrate these components of wisdom in solving real life problems. Baltes and Smith further developed five criteria to assess wisdom-related output (e.g., judgments, advice). These criteria reflect a balance between two wisdom faculties: intellect and character.

The five criteria are:

1. Factual knowledge: Knowing the *what(s)* of the human condition and human nature (e.g., a general knowledge of human emotions and motivation).
2. Procedural knowledge: Knowing the strategies for solving and dealing with life's problems (e.g., timing of advice, monitoring of emotional reactions, and heuristics of cost-benefit analysis).
3. Lifespan contextualism: Knowledge of life's historicity, the settings and social situations, and how these change over time.
4. Relativism of values: Being aware of cultural differences; being considerate and sensitive to different values.
5. Awareness and management of uncertainty: Recognizing the limits of one's own knowledge and understanding and handling the uncertainty of the future.

This model has been criticized for being too focused on cognition and not attending to the reflective and affective aspects of wisdom. A paradigm for understanding this criticism entails a model of a women's way of knowing, proposed by Belenky, Clinchy, Goldberger, and Tarule (1986). The five epistemological perspectives by which women know and view the world (as identified by them) involve the following:

1. Silence
2. Subjective knowing
3. Received knowing
4. Procedural knowing (including two different types of procedures called *separate* and *connected knowing*)
5. Constructed knowing (Belenky et al., 1986)

The highest level of knowing and viewing the world is a *constructed-knowing* stance in which women tend to view all knowledge as contextual. The development of this level of knowledge is aided by self-reflection. In this position of self-knowledge, women are able to have enormous empathic potential. This position of knowing seems to be ignored by the Berlin model of wisdom.

The facilitative factors mentioned in the Berlin model of wisdom are supported by studies emphasizing wisdom-facilitative factors such as life experiences (Brown, 2004; Kunzmann & Baltes, 2005), social interactions (Brown, 2004; Kramer, 1990; Levitt, 1999; Staudinger & Baltes, 1996), reading (Csikszentmihalyi & Nakamura, 2005; Levitt, 1999), religion (Achenbaum & Orwell, 1991; Levitt, 1999), and professional development (Smith, Staudinger, & Baltes, 1994; Staudinger, Maciel, Smith, & Baltes, 1998). To this list of facilitative factors,

Sternberg and Jordan (2005) added general life experience, professional training, practice, and motivational preferences (such as interest in understanding others) that seem to be important rather than intelligence only (Staudinger et al., 1997, Staudinger, Smith, & Baltes, 1992).

Since professional setting, practice, and reading were seen as wisdom-facilitative, the next section reviews studies examining the relationship of wisdom-facilitative settings and professions and the development of wisdom. The Berlin group of researchers initiated a set of studies exploring whether certain experiential settings (professional careers/settings) had a potential facilitative effect on the development (and expression) of wisdom. The Berlin group of researchers highlighted the role of occupational training (in human-services related fields) in facilitating the development of wisdom. The rationale for choosing the psychotherapy profession for study was the understanding that the role of providing wise counsel on difficult matters of personal life is often the work of psychotherapists in western societies. Because of this role, psychotherapists are seen as wisdom-bearers in western culture. The Berlin group of researchers hypothesized that professional training in human-services related fields developed an individual's sensitivity and rhetoric skills, as well as the ability to evaluate difficult human life situations. Baltes and Smith (1990) further proposed that training in these occupations sensitizes a person to the contexts, variations, subjectivity, and uncertainty inherent in giving advice on human problems. Further, they hypothesized that sensitivity to contexts and uncertainty of knowing are factors in wisdom development.

To understand the role of *occupation in the development of wisdom,* a detailed summary of four studies by the Berlin group of researchers are presented and show the trajectory of research that led wisdom theorists to conclude that psychotherapists (with their training and education)

have a tendency to perform better than the average person on tasks measuring wisdom. The section concludes with implications for understanding this study on clinical wisdom of psychotherapists.

Study 1. The aim of this first study undertaken by the Berlin group of researchers involved investigating the role of professional specialization (in human services) and age (older age) on wisdom performance tasks (Staudinger et al., 1992). Women from two age groups (younger with a mean age of 31 and older with a mean age of 71) and two professional backgrounds (human services and nonhuman services) were asked to respond to a life dilemma of a woman who was either young or old. Therefore, the researchers had a 2 (age groups) x 2 (occupations) x 2 (problem-age) analysis. The results showed that the clinical psychologists outperformed the control group, older adults performed as well as the young adults and lastly, wisdom-related performance was enhanced by the match between their own age and the age of the character in the problem task. The results verified the Berlin group of researchers' hypothesis that some occupations exist that could be labeled *wisdom-facilitative*. Researchers stated that the reasons for certain occupations being wisdom-facilitative were that (a) wisdom-facilitative occupations train people in fundamental issues of human existence, (b) wisdom-facilitative occupations understand the certainty of the uncertainty of correct solutions to most human problems, and (c) there are mentors and tutors to guide people along this professional path. However, another important study finding was that in general, wisdom is *rare*. While clinical psychologists performed better than the control group, they did not perform (verbal responses to life dilemmas) at a level that could be labeled wise by the Berlin criteria. The rating of wisdom (presented in Study 1-Study 4) were performed by trained raters selected from the general

population. These raters were selected through a rigorous screening process and subsequently trained using representative protocols of low, average, and high-wisdom responses. The rating was based on a 7-point scale with very clear guidelines from the Berlin wisdom criteria. Seven was the ideal or top score, three or four was average, and one was poor. Thus, the researchers reported the performance of the clinical psychologists was average and concluded that wisdom is a rare attribute.

Study 2. In a second study of occupational settings facilitating wisdom, two groups of clinical psychologists (older with a mean age of 70 years and younger with a mean age of 32years) took part (Smith et al., 1994). Twelve psychologists were in each group. In addition, two control groups of age-matched professionals from the journalism, education, and arts and culture fields were included in the research design. The groups were given two life-planning problems. Individuals in all the groups responded to the problem by commenting on what they thought the people in the problem should do and plan for in the next 3-5 years. The protocols generated were then rated by trained judges. The results showed a significant main effect for occupation with clinical psychologists being rated higher than the control professionals. However, their performance was only average, as rated by the trained judges on the Berlin wisdom criteria. Also, very few responses hit the top-range scores. This study again supports the hypothesis of wisdom being a rare attribute. There was also a significant relationship of the age of the therapist matching the age of the person in the problem presented to the therapists. People showed more wisdom-related knowledge when commenting on an age-matched dilemma. This study indicated that there is not a special advantage to old age, confirming some previous studies done on adolescent wisdom. Studies carried out on adolescents showed higher wisdom-related performance on tasks

where the protagonist was an adolescent (Pasupathi, Staudinger, & Baltes, 2001; Smith & Baltes, 1990). This does raise an interesting question of whether psychotherapists be better advising and guiding clients who are in a similar age group as they are.

Study 3. The third study aimed to counter the criticism of the Berlin model of wisdom as biased toward the kind of knowledge possessed by psychologists (Baltes, Staudinger, Maercker, & Smith et al., 1995). Their sample consisted of wisdom nominees, senior clinical psychologists, a young control group, and a senior control group (matched on educational and social statuses). These were tested on a life-planning task (for example, an older woman setting out on a new professional path is asked by her son for support in caring for his small children since his wife died) and an existential life-management task (for example, advising a friend who is suicidal). The results showed that senior clinical psychologists and wise nominees outperformed the control group and younger clinical psychologists on the wisdom-related tasks. Both the wisdom nominees and senior clinical psychologists performed equally well on the task of existential life-management task. The clinical psychologists performed better on the life-planning task. Of interest in this study is that both groups of older clinical psychologists and wisdom nominees performed at an average level and not a high level as expected. This study supports the results of the two previous studies in this section: wisdom is a rare attribute.

Study 4. The fourth study examined gender, profession, personality, and intelligence in relation to wisdom (Staudinger et al., 1998). The results from regression equations showed a strong positive relationship between professional specialization and performance on wisdom-related tasks. Of the total variance in the model (wisdom-related performance score), 29% could be explained by professional specialization, personality, and intelligence. With this model,

professional specialization in clinical psychology contributed the largest share of unique variance (15%) in the wisdom-related score. Further, there was a substantial overlap between personality and professional specialization. This can be understood as either certain personality dispositions that self-select into a certain profession or that certain personalities develop as people advance in their helping careers. This study showed that clinical psychologists differed from other professions on variables of openness to experience and moderate extroversion. Both of these dimensions of personality were predictive of wisdom-related knowledge and performance. Thus, the researchers concluded that professionals who receive training, mentorship, and experience in fundamental issues of life and human condition have higher levels of wisdom-related knowledge as compared to other professional settings. They also concluded that wisdom was closer to personality variables than to intelligence (i.e., personality is a stronger predictor of wisdom-related performance than intelligence).

While the Berlin model of wisdom represents the most influential of the wisdom theories, it has been criticized on several of its tenets by theorists such as Sternberg (1998) and Ardelt (2004). The greater emphasis on cognitive aspects of wisdom, as compared to the reflective and affective, has been contentious. For true wisdom (in addition to the cognitive, the affective, and the reflective) parts need to come together like the strands of a rope (Ardelt, 2004). The Berlin model focuses more on wise performance rather than on the person generating the wise advice, judgment, or answers. Ardelt argued that wisdom resides in the person and cannot be studied independently of the person. Labouvie-Vief (1990) captured the essence of this untenable dichotomy by saying, “Thought and thinker, knower and known, are one single, indivisible unit and it is from this bond that derives the meaning of experience” (pp. 55-56). An additional

criticism of the Berlin model is aimed toward the methodology it used of presenting vignettes and asking people to respond to them. Critics say this method presents limitations because performance in a laboratory does not equal real-life performance. How would the subjects of these studies respond in real-life dilemmas of life involving their own life (Ardelt, 2004)? Another gap in this model involves the inadequate attention to self-reflection and affect management. The personal dimension of emotional regulation and emotional self-management (which have been emphasized by other wisdom researchers such as Ardelt, 2003; Brown & Greene, 2006; Hall, 2010; and Sternberg, 1985), seems relegated to second place after cognition. While Staudinger et al. (1998) mentions efficacy in life-skills and social adeptness in their elaboration of the Berlin model of wisdom, it does not give due importance to emotional intelligence (Goleman, 2006). Emotional intelligence requires self-management, which is further related to the ability to introspect and reflect—attributes that have not been emphasized in the Berlin model of wisdom. Another set of wisdom attributes that have not been highlighted by the Berlin model of wisdom are humor and spirituality, which have emerged as correlates in the work of other wisdom researchers (Ardelt, 2004; Jason et al., 2001).

Sternberg developed a theoretical model of wisdom, which he called the *Balance Theory of Wisdom* (1998, 2000, 2001, 2004, 2005). Sternberg's work on wisdom can be seen as a logical continuation of his earlier work on intelligence and creativity. Sternberg's work is different from the Berlin group of researchers in the focus of research. He shifted the focus from the *quality of judgments* (wisdom performance to an expert level) to a function of *how one makes those judgments* [process, values, and personality; Sternberg (1998)]. The shift in the wisdom field to a process orientation from a more evaluative judgment of outcome or products (such as judgments

and advice) is significant as it moved the field further from *who* and *what* to *how*. Sternberg defines wisdom as follows:

> The application of intelligence, creativity and knowledge, as mediated by positive ethical values, towards the achievement of a common good through a balance among a) interpersonal, b) intrapersonal, and c) extra-personal interests, over the short term and long term to achieve a balance among a) adaptation to existing environments, b) shaping of existing environments, and c) selection of new environments. (p. 347)

The core of Sternberg's (1998) theory lies in the concept of balance, which in turn depends on one's system of values. Sternberg referred to balancing between self and others, balancing short- and long-term perspectives, and balancing changing or coping environmental factors. Wisdom in Sternberg's balance theory emerges through the interaction of the individual with the environment, relying on positive ethical values and knowledge. While other theorists talk about wisdom and its relation to values (such as the common good and moving beyond the self). Sternberg's theory places positive ethical values right at the top. Values determine the dialectical balance between long- and short-term thinking, between self and others, and mediate each choice of the individual.

Sternberg (1998) based his work on previous work done by Clayton and Birren (1980) and Holliday and Chandler (1986) on implicit theories of wisdom (which was discussed earlier in this review). Baltes and Staudinger (2000) looked at the ideas of wisdom held by people and empirically explicated them-statistically. Results from this research indicated that people held prototypes of wisdom, intelligence, and creativity in their thoughts; and ideas about these three were correlated (Sternberg, 1985). In a second experiment, Sternberg (1990) used data from his previous study on implicit theories to derive a psychological (explicit) theory. Sternberg used

nonmetric multidimensional scaling methods to clarify the components of wisdom. The following six components emerged in Sternberg's study:

1. Reasoning ability (related to a unique way of looking at a problem and solving it);
2. Sagacity (displays concern for others, considers advice, understands others, is a good listener, understands oneself, is thoughtful, is not afraid of making mistakes, open to learning from others, listens to all sides of an issue);
3. Learning from ideas and environment (perceptive, learns from others' mistakes);
4. Good judgment (sensible, thinks before taking actions, has a long-term view on issues, clear thinker);
5. Expeditious use of information (experience, age, maturity; seeks out information); and
6. Perspicacity (able to see through things, intuitive, can read between the lines). (Sternberg, 1990, p. 1460)

The Berlin model of wisdom and the Balance theory are very detailed, thoughtful, nuanced, and complex. However, the detail and use of terms such as expertise, specialty, and specialized solutions (in addition to fundamental pragmatics of life, perspicacity, and sagacity) make wisdom seem very obscure and opaque. In fact, some authors have criticized the Balance theory of wisdom as making the concept of wisdom more opaque and harder to understand rather than the reverse (Paris, 2001). Sternberg, as cited in Ferrari and Potworowski's (2008) book, *Teaching for wisdom: Cross cultural perspectives on fostering wisdom*, justifies the complexity by stating "real behavior in real environments is complex, and in particular, wisdom is complex" (p. 42). A summary of the explicit theories of wisdom is given in Table 2.

Table 2. Summary of the Components of Wisdom Based on Psychological Models or Explicit Theories

Year	Related to	Researcher	Components
1996–To Date	Expertise	Baltes, Smith, & Staudinger	• General person factors (cognitive style, creativity, openness to experience) • Facilitative experiential contexts (age, education, profession) • Expertise-specific factors (motivational dispositions, mentorship in dealing with life matters) • Synthesis of the discussed factors (person, facilitative contexts, and expertise-specific) should be toward a common good.
1996	Affect and Cognition	Lyster	In addition to the person factors, facilitative contexts, and expertise-specific factors of the Berlin model of wisdom, Lyster added the following two: • Affect-cognition integration • Generativity
2000, 2003	Cognition	Brugman	• Metacognition (acknowledging uncertainty and ability for dialectical thinking) • Personality/affect (emotional stability despite uncertainty and openness to new experience) • Behavior (ability to act in the face of uncertainty)
1985, 2005	Ethics (values) & Context	Sternberg	• Sagacity • Reasoning ability • Learning from ideas and environment • Good judgment • Expeditious use of information • Perspicacity
1990	Motivation-Affect	Kramer	• Cognitive, affective, and behavioral. • Relativistic and dialectical modes of thinking
1997, 2003, 2004	Affect	Ardelt	• Cognitive • Affective • Reflective (necessary for development of the cognitive)

The question remains whether these scientific models of wisdom, such as the Berlin model of wisdom, privilege certain ways of knowing (e.g., cognitive knowing rather than emotional knowing) versus others. It takes wisdom from the realm of everyday knowledge to a sanitized, privileged scientific construct and in that, justifies one way of knowing (Chandler & Holliday, 1990). It is not clear whether these theories have room to explain wisdom as it is ordinarily understood and seen in day-to-day interactions.

The reason for detailing the explicit and implicit theories of wisdom is twofold. One, it enumerates the personality factors (cognitive, affective, conative, and values) of a wise person; and two, it highlights the processes involved for a product or performance to be labeled wise. From a view of the current research and theories on wisdom, it is apparent that consistent ideas exist about components of wisdom. Differences arise when not all of the same components are viewed as central by every group. People assign different weights to different components (Staudinger & Glück, 2011) based on age, profession, sex, and culture. Perhaps, there exists a common core meaning of wisdom, which is shared with additional room for differences. Starting with Aristotle, who differentiated between practical wisdom and philosophical wisdom, to more recent attempts to differentiate practical wisdom from transcendent wisdom (Wink & Helson, 1997), the attempt has been to correlate (put very simply) the three major components of wisdom, cognitive, affective, and reflective to different types of wisdom. There might be overlap in the types of wisdom (not necessarily in the same person) but they are also recognizably different or conceptually different. One way of imagining the concept of wisdom, as it stands now, is to use a Venn diagram (see Figure 1) with a central core shared by different kinds of wisdom.

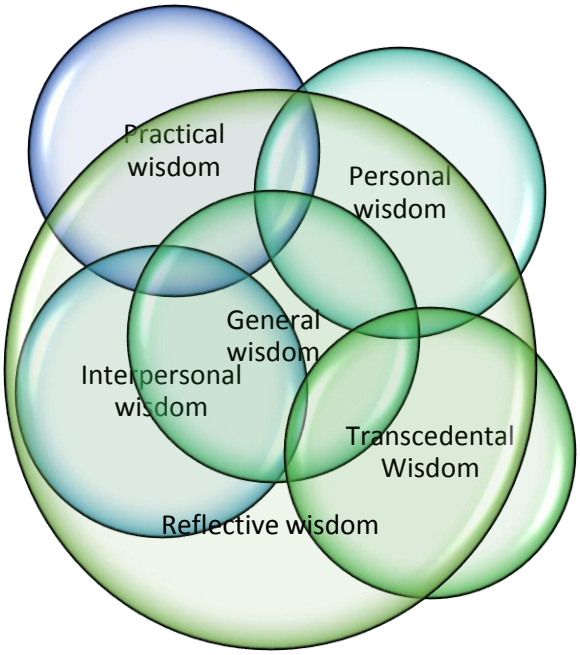

Figure 1. Venn Diagram Illustrating the Concept of Wisdom Types

To add to the complexity in the wisdom research field in the last decade there has been an attempt to conceptually delineate wisdom into *personal wisdom* and *general wisdom* (Staudinger, 1999; Staudinger et al., 2005). Personal wisdom consists of a person's insights into their own lives—a factor strongly related to self-concept maturity—while general wisdom is concerned with insights into life, in general. There exists an ongoing debate as to whether these categories of wisdom can coexist or coincide within a person and if these components can exist independently from each other (Staudinger, 2014). Personal wisdom is seen as distinct from the wisdom needed to give advice on other people's life dilemmas or display sound judgment on difficult life challenges.

There seems to be a difference between self-insight and life-insight (Staudinger et al, 2005). Consequently, the development of personal wisdom dictates that people have very

individualized trajectories in the development of personal wisdom. However, most models of personal wisdom do emphasize difficult, negative events and learning from challenges. Glück and Bluck (2007, 2013) reported that wise people have the following four general resources that influence how he or she deals with challenges and makes them a part of their life story:

1. Mastery
2. Openness
3. Reflectivity
4. Emotional regulation and/or empathy, which form the acronym MORE.

The MORE resources form a positive complex, which help people deal with life challenges differently and in a way that fosters wisdom. (Glück & Bluck, 2013). The step of making implicit models like MORE scientifically valid hold the promise of a bridge between what people think and know about wisdom to the psychological models and theories of understanding wisdom.

With the differentiation of wisdom into personal and general wisdom categories, it is not clear where a concept such as clinical wisdom falls. Feeling wise with clients in therapy may be its own unique kind of wisdom, which may or may not occur with other kinds of wisdom in a therapist. Clinical wisdom may share attributes with interpersonal wisdom or reflective wisdom, but these hypotheses remain to be tested.

Defining Wisdom

Many definitions have been proposed by various researchers. While significant overlap exists, so too does significant differences. Table 3 presents a summary of the definitions of wisdom proposed by researchers. Table 3 has been artificially divided into two parts: one, which

summarizes definitions highlighting the cognitive aspects of wise people and two, which highlights the role of the personality factors of wise people to define wisdom.

Many definitions have been proposed by many researchers. Jeste et al. (2010) implemented a study to see if there was indeed some consensus amongst the experts in the wisdom field. The results of their Delphi poll showed wisdom as a distinct entity from intelligence, creativity, and spirituality (although they were all correlated). Wisdom is uniquely human—a form of advanced cognitive and emotional development that is experience-driven; and a personality quality. Wisdom increases with age, can be measured, and is rare among the general population. Jeste et al. also reported that the inclusion of spirituality is tenuous, with most definitions leaning toward a secular stance. In a relatively recent review of literature by Bangen, Meeks, and Jeste (2013), the most common subcomponents of all definitions of wisdom across studies were social decision making and pragmatic knowledge of life; prosocial attitudes and behavior (which include empathy, compassion, and fairness); reflection and self-understanding; coping effectively with the uncertainty of life; and emotional homeostasis.

The plethora of definitions that exist share more commonalities than differences. In this regard, having a working definition of wisdom can be very useful (e.g., "Wisdom is the competence in, intention to, and application of, critical life experiences to facilitate the optimal development of self and others" (Webster, 2003, p. 172). In this definition of wisdom, critical life experiences refer to "rich and varied experiences in interpersonal contexts, particularly those requiring resolution of difficult life choices; coping with important life transitions; and exposure to life's darker side (e.g., dishonesty, hypocrisy)" (Webster, 2003, p. 172). This definition

includes cognitive, affective, and reflective traits that tie in with Ardelt's (2004) work and those of other researchers.

Table 3. Summary of the Important Definitions of Wisdom

A. Highlighting cognitive aspect/thinking style

Researcher	**Year**	**Definition of Wisdom**
Sternberg	2005	• Wisdom is "a metacognitive style plus sagacity, knowing that one does not know everything, seeking the truth to the extent that it is knowable" (Sternberg, 2005, p. 16).
Meacham	1990	• Wisdom is an awareness of the fallibility of knowing and is a striving for balance between knowing and doubting.
Arlin	1989	• Wisdom is closely associated with problem-finding ability, a fundamental cognitive process of reflection and judgment.
Kitchener & Brenner	1990	• Wisdom is the intellectual ability to be aware of the limitations of knowing and how it impacts solving ill-defined problems and making judgments, characteristic of reflective judgment.
Pascual-Leone	1989	• Wisdom is a mode of symbolic processing by a highly developed will. It is a dialectical integration of all aspects of personality including affect, will, cognition, and life experiences.
Baltes & Smith; Baltes & Staudinger	1990; 1993, 2000	• Wisdom is "expert knowledge concerning the fundamental pragmatics of life" (Baltes & Staudinger, 2000, p. 124).

B. Highlighting personality factors

Year	**Researcher**	**Definition of Wisdom**
Ardelt	2003	• Wise persons are presumed to have an integrated personality, exceptional maturity, superior judgment skills in difficult life matters, and the ability to cope with life's vicissitudes (Ardelt, 2003).

Note: Summarized from Sternberg 1985, 1998.

Measuring Wisdom

The preceding Defining Wisdom section dealt with wisdom as defined by different theorists depending on their perspective (e.g., developmental, gerontology, education). While there has been considerable overlap, there also exists significant differences theoretically. These differences impact the way data is collected to measure and study wisdom, as well as the other way around too. As a result, the authors of these definitions went on to develop scales for measuring *their* conceptions of wisdom.

Most measures of wisdom can be categorized into two different but overlapping ways: *self-report* measures and *performance-based* measures (Staudinger & Glück, 2011). Another distinction between measures on wisdom depends on whether these measures can capture an individual's insights into their own life based on their personal experiences versus if he or she captures general wisdom. It is not clear whether a particular type of wisdom is being measured by the instrument or whether the result approximates a global estimate of wisdom

It is also interesting to note that while these instruments measure wisdom, as defined by the researchers, there are alternate ways to measure wisdom—depending on what construct is seen to approximate it most closely. For example, an instrument measuring empathy, emotional intelligence, social judgment, or ego-strength could lend itself as a good measure of wisdom too. Comparing the correlates of wisdom in this way could further differentiate the construct of wisdom. Statistically, it could help separate the exact variance contributed by wisdom from other similar variables when studying related constructs of well-being, life satisfaction, and optimism.

The reason for enumerating the measures in detail also adds to the way wisdom as a construct has been conceptualized by researchers. Each way of measuring has its limitations and

can be seen to approximately measure some part wisdom. Unless the researcher is clear about the nature of wisdom being measured and uses appropriate measures, any tool can be justified as a measure of wisdom. There are almost as many measures of wisdom as there are definitions.

Description of the Scales

A review of the three most frequently used self-report measures for wisdom and three performance-based measures follow:

1. Three-Dimensional Wisdom Scale (3D-WS)
2. Self-Assessed Wisdom Scale (SAWS)
3. Adult Self-Transcendence Inventory (ASTI)
4. Berlin Wisdom Paradigm (BWP)
5. Bremen Wisdom Paradigm
6. Transcendent Wisdom Rating

Of these six scales, only the BWP represents a measure of general wisdom; the rest are measures of personal wisdom.

Three-Dimensional Wisdom Scale (3D-WS) (Ardelt, 2000, 2003, 2011)

The Three-Dimensional Wisdom Scale (3D-WS) measures three components of wisdom: the reflective, which is considered necessary for the affective and cognitive components to develop. The scale consists of 39 items that measure cognitive (14 items), reflective (12 items), and affective (13) dimensions of wisdom as per Ardelt's (2004) definition of wisdom. Of these items, 24 are presented with a 5-point response scale (marked as *definitely true of myself* to *not true of myself)* and 15 are presented with a 5-point Likert scale from *strongly agree* to *strongly*

disagree. The items on the reflective dimension are about questioning one's role in difficulties and the ability to take the perspective of the other.

The analysis of the 3D-WS shows that it has adequate reliability and validity. Construct, predictive, and discriminant validity (lack of correlation with sociodemographic data and social desirability), and internal test-retest validity of the 3D-WS are high. Content and convergent validity were also found to be satisfactory. This scale is one of the most rigorously developed scales and has significant positive correlations with various measures of well-being and significant negative correlations with measures of depression, stress, and avoidance.

Self-Assessed Wisdom Scale (SAWS) (Webster, 2003)

The Self-Assessed Wisdom Scale (SAWS) is a scale that measures five components of wisdom: openness, emotional regulation, humor, critical life experience (decision-making and knowledge), and reminiscence and self-reflectiveness. The scale consists of 40 items presented on a Likert scale ranging from *strongly disagree* to *strongly agree*. A criticism of this scale involves subscales (e.g., humor, openness to experience) being considered as predictors or consequences of wisdom rather than the essential elements of wisdom (Ardelt, 2011). This scale is reflective of Webster's 2003 working definition of wisdom namely, "Wisdom is the competence in, intention to, and application of, critical life experiences to facilitate the optimal development of self and others" (Webster, 2003, p. 172). In his definition, *critical life experiences* refer to important personal experiences, which are "morally ambiguous, multifaceted, and fraught with unknown outcomes" (Webster, 2007, p. 167).

Adult Self-Transcendence Inventory (ASTI) (Levenson, Jennings, Aldwin, & Shiraishi, 2005)

The Adult Self-Transcendence Inventory (ASTI) measures self-transcendence and is based on Tornstam's (1994) concept of gerotranscendence. Tornstam (2001) defines gerotranscendence as a developmental stage that occurs when older adults shift their perspective ". . . from a materialistic and rational view of the world to a more cosmic and transcendent one, normally accompanied by an increase in life satisfaction" (p. 166). The ASTI scale does not overtly measure wisdom but measures self-transcendence. With the ATSI, wisdom is not measured directly but is inferred by measuring other constructs that are theoretically very similar to wisdom and in some cases used interchangeably. Self-transcendence is one such construct related to moving beyond the conventional ways of thinking, feeling, and acting. Moving away from conventional modes of thinking, feeling, and action (self-transcendence) is seen as a developmental pathway to wisdom (Le & Levenson, 2005; Pascual-Leone, 1990; Shiraishi, 2005). It reflects a decreasing reliance on externals for definition of the self-increasing interiority and spirituality—and a greater sense of connectedness with past and future generations.

The ASTI included items based on Curnow's (1999) four features of wisdom, namely self-knowledge, detachment (from self-interests), integration, and self-transcendence. The original ASTI was positively related to openness to experience, extraversion, meditation practice, and egalitarianism and it was negatively related to neuroticism, competitive individualism, and immature love (Le & Levenson, 2005; Levenson et al., 2005).

Berlin Wisdom Paradigm (BWP)

The Berlin Wisdom Paradigm (BWP) measures general wisdom. Unlike the previously discussed self-report measures, it was a performance measure of wisdom-related knowledge based on the theoretical framework of wisdom given by Paul Baltes and the Berlin group of researchers. It rests on the definition of wisdom as expertise in the fundamental pragmatics of human life (Baltes & Smith, 1990; Baltes & Staudinger, 1993, 2000). In the BWP, participants responded to vignettes about challenging human dilemmas. These were then rated by a panel of trained raters on a Likert-type scale. This method of assessment owes its methodological roots to the method of thinking aloud protocol originally developed in cognitive psychology. The following is an example of a vignette the Berlin group used to elicit responses to judges as wise:

> Imagine that someone gets a call from a friend who says he or she cannot go on anymore and wants to commit suicide. Before the problem is presented to the participants, they are told (a) they should talk about what they think without pausing, (b) there are no right or wrong answers to the problem, (c) the researchers are interested in specific as well as general aspects of the problem, and (d) they should themselves decide when they would like to finish.

The BWP method has established internal consistency, inter-rater reliability, and test-retest reliability. In addition, it has shown convergent validity and discriminant validity with similar constructs such as personality and intelligence.

Bremen Wisdom Paradigm (Mickler & Staudinger, 2008)

The Bremen Wisdom Paradigm task was similar to the BWP in that it is also a think-aloud task about a vignette except it focuses on judgment and advice about *one's own* difficult life and uncertain situations rather than a friend or other individual. The authors tried to differentiate wisdom into two subtypes conceptually—wisdom about life in general (i.e., from an

observer's viewpoint) and wisdom about one's own life. Personal wisdom was viewed as a possible indicator of personality maturity (Staudinger & Kunzmann, 2005). The Bremen Wisdom Paradigm has faced criticism (similar to that of the BWP) of overemphasizing cognitive aspects of wisdom (Glück et al., 2013).

Transcendent Wisdom Rating (Wink & Helson, 1997)

The Transcendent Wisdom Rating represents a combination of an interview and a questionnaire format and measures wisdom. The wisdom components that this hybrid scales measures are decision making, prosocial values, self-reflection, and acknowledgment of uncertainty, tolerance, and spirituality.

Given there exists so many scales to use to measure different aspects of wisdom, it becomes difficult for a researcher to choose an appropriate measure. It does not help that correlations among most wisdom measures are surprisingly low—indicating that measures reflect different values (Glück et al., 2013; Taylor, Bates, & Webster, 2011). In a comparison of four well-established measures, Glück et al. (2013) concluded that all measures of wisdom measure either *personal wisdom*, *general wisdom*, or *other-related wisdom*. Personal wisdom refers to what individuals have learnt about themselves, others, and the world through their own experiences; and the basic source of this knowledge is self-reflection and introspection. General wisdom refers to wise ways of thinking about complex problems without an involvement of one's own self or particular concern for other people. Not often spoken of explicitly in research on wisdom but implicit in all theories of wisdom (especially among the general population), other-related wisdom refers to an empathy-based caring and concern for other people and humankind at large. It is seen as similar to some aspects of altruism and generativity.

In conclusion, it was suggested that researchers looking for a measure for their study should first determine their focus and the nature of wisdom they are interested in studying. Webster's (2003) definition of SAWS is good for studying personal wisdom. Ardelt's (2004) 3D-WS spans a broad range including other-related wisdom. The BWP (Baltes & Smith, 1990) represents a good measure of general wisdom.

Limitations of the Existing Measures of Wisdom

Glück et al. (2013), in a review of measures, acknowledged that differentiating the correlates of personal, general, and other-related wisdom is not an easy exercise and is in fact, rather messy. A hypothesis put forward by Glück et al. stated that while wisdom measures are theoretically and content-wise very disparate, they may all tap into a "wisdom syndrome" that includes personal, general, and other-related aspects (p. 5). Most measures tap into the general and personal wisdom well. It is the other-related aspect of wisdom (which includes empathy based caring and concern) that has not been covered optimally by the existing measures.

Self-report measures and performance measures have their limitations—especially when a positive social value such as wisdom is measured. Wise people are humble (Ardelt, 1990, as cited in Hall, 2010, p. 54); they are unlikely to declare themselves as wise. Wise people also tend to be self-critical and embrace the wisdom of not-ever-arriving at the status of being wise (Aldwin, 2009; Assmann, 1994; Redzanowski & Glück, 2013). Jeste et al. (2010) explained, "You can't expect a wise person to rate themselves as 10 on a 1 to 10 rating scale asking them how wise they are" (p. 678). Lastly, according to Freund and Kasten (2012), most people are not particularly good at judging their own competencies, including competence in tasks related to

wisdom. Despite the criticisms, self-reports are used in measuring wisdom in conjunction with performance measures.

Performance measures overcome the issues with self-report measures of wisdom, but have their own set of challenges including cost, training of people to rate protocols, and requirements of large investments of time and effort. Another criticism of performance measures of wisdom comes from the nature of the task itself. People could display much wisdom when it comes to advising others (i.e., wisdom on a task that is removed from one's own life) but that does not ensure they will display the same level of wisdom when it comes to their own lives. In sum, there are many measures of wisdom that exist but unless the type of wisdom being measured is clearly defined by the researcher conceptually, using measures uncritically can lead to more confusion than clarity about wisdom.

Relation of Wisdom and Psychotherapy

So far, this review has covered the definitions of wisdom, theories of wisdom, and an overview of the methods used to assess wisdom. The next section reviews research studies to discover if any parallels exist between the components of wisdom just discussed and elements of effective psychotherapy and expert psychotherapists. The end of this section summarizes the attributes of wise people that are also reflective of wise psychotherapists (to be used interchangeably with therapists and counselors).

There are some definite parallels between psychotherapy and wise advice and judgments, "Both draw on imagination, on hypothetical constructions and supporting fictions, to open up new visions for reflection, a new space for action, and a new stimulation for emotions" (Assmann, 1994, pp. 193-194).

As in therapy, wisdom recognizes that there exist no definite solutions to the fundamental problems of life (Assmann, 1994). In fact, in the helping professions in general, and social work specifically, the acknowledgment and examination of uncertainty is seen as a competency, which is desirable (Spafford, Schryer, Campbell, & Lingard, 2007; Winnicott, as cited in Summers, 2013). Spafford et al. (2007) concluded that social work students viewed the acknowledgment and examination of uncertainty as a touchstone of competent social work. Knowledge is viewed as situational, context specific, and person specific.

Skovholt and Rønnestad (1995) in their discussion of stages of counselor development, wrote that expert level therapists have acquired "accumulated wisdom" (p. 89). These expert level therapists reject the known and defined understanding of human behavior (Rønnestad & Skovholt, 2013). These therapists have the ability to go beyond textbook theories and operate from an internalized personalized theory of therapy developed from years of practice, experience, reflection, and intuition. In a similar vein, characteristics of wisdom are well-captured in the following quote by Assmann (1994):

> . . . (wisdom) abstains from the zealous hope of changing the fundamental conditions of life or of solving particular problems once and for all. It accepts the fact that there are no definite solutions and that the course of life remains always essentially unstable, threatened by dilemmas and crises. Under these circumstances wisdom looks for strategic devices to make life more bearable and worthwhile. Such knowledge cannot be lifted from any specific situation nor can it be severed from the knower. It is rendered in the form of a theory or a gnomic phrase and not in that of an abstract rule or a universal law. (p. 194)

Research suggests that wisdom is a necessary component in effective counseling (Hanna & Ottens, 1995). The plethora of existing theories reveal the complexity of the process of psychotherapy (Hanna & Ottens, 1995). It is important to determine whether wisdom can explain

why some therapists are more effective. It may be that wisdom is the common factor that can help psychotherapy researchers understand at least some of the differences between therapists who are less effective, more effective, or qualify as master therapists (Hanna & Ottens, 1995).

There are many ways to study wisdom; for example, by examining cultural stories, proverbs, and literature (Staudinger & Glück, 2011), and looking at the wise person. Wisdom researchers have looked at the wise person by identifying their personality characteristics, age, experience, gender, and occupation. Therapists have also been studied for expertise and wisdom via their training, professional experience, age, gender, and personality characteristics. The next section reviews the studies on the attributes of wise people and expert therapists in parallel to determine if any overlap exists in the two areas of study.

Wisdom and Gender

The role of gender in psychotherapy has been studied from the perspective of the client as well as the therapist. Blow, Timm, and Cox (2008) concluded that gender alone does not appear to influence clinical outcomes directly, except in some cases for adolescents. The relationship between gender, therapeutic alliance, and treatment outcome is both complex and inconsistent (Bhati, 2014; Huppert et al., 2001). The inconsistency (with regard to gender) can be summarized as three competing hypotheses:

1. Female therapists are more effective than male therapists.
2. Better outcomes are predicted when clients and therapists are matched on gender.
3. Therapist gender is not related to therapy outcomes. (Bowman, 1993)

Given that men and women are socialized differently, it is possible men and women have different pathways to wisdom. Orwoll and Achenbaum (1993) seemed to think so, while at the

same time suggesting that wise individuals were likely to be androgynous. The Jungian archetype of the *wise old man* captures well that the conventional wise person is in the minds of laypeople: an old man with greying hair and white beard. This archetype gets manifested in popular culture; for example, Gandalf (Hobbit and Lord of the Rings), Merlin (wizard featured in Arthurian legend and medieval Welsh poetry), Obi-wan Kenobe (Star Wars), and Dumbledore (the wise wizard from Harry Potter).

Theorists such as Levenson (2009) have pointed to a gendered split in the study of wisdom. One set of approaches in wisdom research is seen as privileging the masculine aspects such as cognition and rational aspects of wisdom; the other set gives importance to affect, compassion, and intuition. Wisdom scholars comment that this split is unnecessary, and a movement is seen in the wisdom field toward integration of the cognitive with the relational and affective yielding a more androgynous whole.

Wisdom and its Relation to Age and Experience

When examining the characteristics of age and experience, it is difficult to control for the effect of one on the other. In other words, the effect of age and experience is often confabulated so it is difficult to determine the individual effects. As therapists gain practice years, in parallel, they also gain chronological years. This movement across career levels has been associated with a sense of professional development (Orlinsky & Rønnestad, 2005). In Orlinsky and Rønnestad (2005), older therapists reported feeling wiser in their close personal relationships (as compared to younger therapists); and many of them were in active psychotherapeutic practice. Gratitude, tolerance, becoming realistic, and humility have also been reported in self-reports of senior therapists (Rønnestad & Skovholt, 2013). These qualities are associated with wise people in

general population. Huppert et al. (2001) examined the role of experience in 14 experienced Cognitive Behavioral Therapy (CBT) therapists and found that clients seen by more experienced therapists had better outcomes. However, Huppert et al. found no relation of client outcome with age and gender. Both process and outcome differences have been seen with different levels of experience in therapists (Hill and Knox, 2013).

Wisdom has long been commonly associated with old age. Perlmutter, Adams, Nyquist, and Kaplan (1988) found that 78% of their population related wisdom to age. Persons nominated as wise were aged 50 or above and nominee age increased with the respondents age. One possible explanation for this relationship incorporates the growing awareness of the finitude of life. The certainty of death and coming to peace with the past are associated with the development of a wise perspective. The second possibility of the association of aging and wisdom can be the fact that age brings with it the capacity (time and willingness) to examine past events (Assmann, 1994). In fact, wisdom represents one of the few positive associations of old age (Heckhausen et al., 1989). However, it is equally important to remember that "growing old is a necessary but not sufficient condition for emergence of wisdom" (Moody, 1986, as cited in Ardelt, 2000, p. 783).

Difficult personal experiences (both personal and sociohistorical) and their role in the development of wisdom are related to the discussion about wisdom and aging, albeit indirectly. A popular belief is that people who are older in years have faced a greater number of challenging circumstances and events than someone much younger. It has been found that difficult circumstances are opportunities for the development of wisdom, but do not automatically lead to wisdom (Assmann, 1994; Pascual-Leone, 2000). Ardelt (1998, 2004, 2005) added an important

aspect of *reflection* to the wisdom conversation. She said that difficult personal circumstances can lead to wisdom *if* people are willing to learn from them and be transformed in the process. Skovholt and Rønnestad (1992) stated that extensive experience with suffering produces *heightened tolerance and acceptance of human variability*. Wisdom theorists have also spoken about the role of traumatic incidents, reflecting on them as a positive factor in the development of wisdom (Linley, 2003). It makes people recognize uncertainty, manage the emotions that follow, and recognize the limits of human existence. This focus on positive adaption to trauma represents a crucial addition from the wisdom field to the therapist development process. Exposure to trauma is not enough; it must be followed by reflection and assimilation of the affect following that trauma in order to lead to wisdom.

Wisdom and Psychotherapy: The Role of Personality Factors

Wampold (2010) articulated that it is the human qualities and attributes utilized in therapy that explain the healing power of therapy. Research has shown that therapists' account for a greater role in treatment effectiveness than the treatment modality (Wampold, 2001; Wampold & Brown, 2005). As Rønnestad and Skovholt (2013) stated, "Indeed, 'therapist effects' are much more important than 'method effects', and therefore who the therapist is, is much more important than the therapeutic method used" (p. 7).

Rosenzweig (1936) identified the "yet undefined effect of the personality of the therapist" as an essential common factor that influences client change (p. 415). However, it is understood that the personal attributes of the therapist influence the *therapeutic working alliance*. Alliance is the pan theoretical factor that has been consistently linked to better outcome (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985). Research has identified personal qualities like

warmth, encouragement, and empathy as important contributors to the alliance (Beutler, Machado, & Neufeldt, 1994; Kim, Wampold, & Bolt, 2006; Lambert, 1992; Ottens & Klein, 2005). In a review of literature from 1988 to 2000, Ackerman and Hilsenroth (2003) summarized the personal attributes and techniques of therapists that positively influence therapeutic alliance. These attributes included flexibility, experience, honesty, openness, respectfulness, trustworthiness, confidence, interest, alertness, friendliness, and warmth. Sandell et al. (2006, 2007) found kindness, creative style, and neutrality as factors related to positive treatment outcomes. Laska, Smith, Wislocki, Minami, and Wampold (2013) reported the importance of flexible interpersonal style and all the Rogerian qualities of a nonjudgmental stance (neutrality unconditional positive regard [acceptance], good verbal skills, and responsiveness) as the qualities that cut across all domains of the effective therapist. What intrigued psychotherapy researchers was determining which of these qualities of effective therapists were pretreatment personality characteristics, or whether they were qualities that emerged in treatment (related to the client factors and context factors). Heinonen (2014) summarized it well by saying both personal and professional qualities of a counselor determine what makes one clinician better than the other. These qualities include both what Orlinsky and Howard (1987) called the task-instrumental and the social-emotional aspects of therapy work. The task-instrumental qualities deal with the therapists' skillfulness, difficulties, coping mechanisms, and attitudes and beliefs regarding treatment. The social-emotional aspect refers to factors that help build the alliance and the relationship. The social-emotional aspects are the therapist's relational manner, attachment style, and management of one's own interpersonal issues. Of these, the therapist's skillfulness and professional relational manner seem to be related to client-rated alliance factors (Nissen-Lie

et al., 2010). A relevant parallel in wisdom debate was summed by Ardelt (2004) "wisdom is conveyed *not only* through the content of the statement, but through the way the statement is delivered" (p. 262). Likewise, in the process of psychotherapy, how and what the psychotherapist says has a large impact on how the client will respond and experience the communication.

A summary of the therapists' characteristics, as it relates to a positive therapeutic relationship, is detailed in Table 4.

Characteristic of Master Therapists and Those of Wise People

Dlugos and Friedlander (2001), in their qualitative study of 12 "passionately committed psychotherapists," found these therapists had balance in their lives, were able to create boundaries between their professional and personal activities, were adaptive and open, had a sense of *transcendence* (acknowledging a spiritual dimension to the work of therapy) and humility (e.g., they viewed providing therapy as a social responsibility), and engaged in *intentional learning* (they were open to new experience and new sources of learning; continued fascination with human development and change; p. 298). The study participants scored in the 99th percentile on *openness to experience* and had a high sense of personal achievement. What is not clear is what impact this *openness to experience* has on the boundaries of the treatment frame, whether they would be held more flexibly by the therapist and whether this would be due to an ability to be creative, less rigid, and more self-reflective (Wink & Dillon, 2013).

Harrington (1988) studied master therapists and found them to be *emotionally* stable, kind, empathic, sensitive; *cognitively* intelligent and competent; *relationally* consistent and reliable, honest, and given to grow and succeed. When looking at the practice of these therapists

in this study, a second set of variables emerged, namely: (a) *therapy skills:* competent, theoretical knowledge, technical skills and intelligence, (b) *relationship skills*: warm, caring, kind, empathic, compassionate, and (c) a *strong sense of se*lf, which helps in maintaining the therapeutic frame. Jennings and Skovholt's (1999) study of master therapists led to the development of the cognitive, emotional, and relational model (CER) to describe the personality characteristics of master therapists. In the *cognitive* sphere, master therapists value cognitive complexity and embrace ambiguity of the human condition. In the *emotional* domain, master therapists are self-aware, reflective, nondefensive, open to feedback, and mature. In the *relational* domain, master therapists possess strong relationship skills and appear to be experts in using these strong relationship skills to build strong therapeutic alliances with their clients.

Table 4. Summary of Therapist Characteristics Related to Positive Therapeutic Relationship

Researchers and Year of Study	**Therapist Characteristics**
Beutler et al., 1994; Ottens & Klein, 2005; Lambert, 1992; Kim et al., 2006	Warmth, encouragement, and empathy
Ackerman & Hilsenroth (2003)	Flexibility, experience, honesty, openness, respectfulness, trustworthiness, confidence, interest, alertness, friendliness, and warmth
Sandell et al. (2006, 2007)	Kindness, creative style, and neutrality
Nissen-Lie et al. (2010)	Professional self-doubt, humbleness, sensitivity
Laska et al. (2013)	Flexible interpersonal style, nonjudgmental stance, neutrality unconditional positive regard (acceptance), good verbal skills, and responsiveness

In the wisdom literature, the social and cultural context made some differences in the identification and description of wisdom (Jeste & Vahia, 2008; Takahasi & Bordia, 2000; Takayama, 2002). A similar trend was seen in the studies on master therapists outside the United States. Master therapists from Canada, Japan, and South Korea had many similarities as well as a few differences with American therapists (Jennings, Skovholt, Goh, & Lian, 2013). The commonalities included a strong interest in new learning, the importance of self-reflection and self-awareness, humility, empathy, a nonjudgmental attitude, a flexible therapeutic attitude, not being afraid of experiencing strong emotions or expressing them (self-disclosure), acceptance of ambiguity, an exceptional ability to form trustful relationships and lastly, the ability to embrace and accept the complexity of human condition and therefore the problems that the clients have.

In multicultural counseling studies, the ability to take another's perspective and to gain a deep understanding of another person's experience was considered critical for developing cultural competence (Hanna et al., 1999) and multicultural counseling (Phan, Rivera, Volker, & Maddux, 2009). Further studies point to a positive relationship between a therapist's multicultural competence and therapy outcomes (Kim & Lyons, 2003).). However, it is not yet clear whether mastery and cultural competence are related. Goh, Starkey, Jennings, and Skovholt (2007) studied this question and reported that multicultural master therapists possess a strong sense of cultural competency, are avid cultural learners, are self-aware, are relational experts, evidence cross-cultural strategizing, and believe that training in culturally specific knowledge is important.

Based on these studies of master therapists, Rønnestad and Skovholt (2013, p. 238) put forth a revised portrait of master therapists based on the cognitive, emotional, relational (CER) model (Jennings & Skovholt, 1999).

The CER elements incorporate the following:

- Cognitive. Embraces complexity and ambiguity, guided by accumulated wisdom, insatiably curious, profound understanding of the human condition, voracious learner, and has cultural knowledge and competence.
- Emotional: Deep acceptance of self, genuinely humble, highly self-aware, intense will to grow, and enjoys life passionately.
- Relational: Able to intensively engage others, acute interpersonal perception, nuanced ethical compass, boundaried generosity, relational acumen, openness to feedback, and trust in clients.

Based on research on master therapists, the qualities of high self-awareness, strong relational acumen, sharp and comprehensive clinical conceptualization, voracious learning, high emotional health, a healthy mix of humility and confidence and lastly, flexibility in clinical interventions, distinguish them from other therapists. These same traits or qualities have also been identified in wise people in the research which may indicate that master therapists could also be characterized as wise. Unfortunately, a lack of empirical data of client improvement represents a general criticism of most studies of master therapists (Orlinsky, 1999). The aim in highlighting this difference involves taking mastery in therapy skills beyond a narrow scope of proficiency in skills (cognitive proficiency) to a level where it incorporates the person of the

therapist. Mastery status has aspects of humility, intuition, self-reflection, and creativity, which have a transformational effect on the therapist's work and in turn, affect the person of the therapist. Rønnestad and Skovholt's (2013) study on master therapists identified them as more than merely skill proficient, but also able to function at a very high level in both the domains of *being* and *doing*. The assumption is that most people function well at either *being*, which seems more inactive and reflective or at *doing*, which relates to action and movement. However, master therapists have the ability to embrace paradox in general and specifically, their ability to be in action yet be of a quiet mind mirrors that of wise people.

The being and doing difference has been highlighted by wisdom researchers as that which distinguishes the truly wise in the general population. Ardelt's (2004) criticism of the Berlin model as excluding the experiential and transformative effects of wisdom highlights this difference of being and doing. Ardelt argued that wise knowledge resides in the wise person and is more than a cognitive/intellectual/knowledge based product. Because wise persons are transformed by their wisdom in that manner wisdom transcends the intellect (Ardelt, 2000; Assmann, 1994). Knowing a wise answer does not make a person wise. Kekes' (1983) pithy response is, "a fool can learn to say all the things a wise man says and to say them in the same occasion" (p. 286).

A similar quandary has also puzzled but not surprised the psychotherapy research field: that perspectives of clients and therapists differ on the alliance, its qualities, and what makes alliance helpful (Bachelor, 2013). This finding has emphasized the importance of considering the perspective of both parties involved in the treatment when talking of constructs such as therapeutic alliance or what works in therapy. Because the two perspectives may be different

does not mean a relationship does not exist. The therapists' perceptions of who they are and what they are doing that is helpful has an influence on their self-perception, confidence and consequently, the outcomes experienced by the clients (Heinonen, 2014). Clients may only have the perception of the result of the therapeutic process and not know the therapist's experience. This point underscores the need for studies relating to the self-perceived qualities of therapists and therapist perspectives on what it is they do that works to make therapy successful.

The qualities of therapists linked to effectiveness can be collated under four domains of cognitive, affective, reflective, and relational qualities. The following four domains of therapist qualities are examined and compared with qualities of wise people from wisdom literature:

Cognitive: Cognitive complexity, metacognition, problem-solving, dialectical reasoning, and intellectual curiosity.

Affective: Emotional intelligence, curiosity, moderate levels of happiness and sadness, and empathy

Reflective: Self-reflection, dealing with uncertainty, reflectivity

Relational: Strong interpersonal skills; using the skills to solve complex human dilemmas

Parallels in the Wisdom Field and Psychotherapy in the Context of Cognitive Complexity

Cognitive complexity involves the ability to absorb, integrate, and make use of multiple perspectives. Individuals using cognitively complex perspectives ask questions, withhold judgment, look for evidence, and adjust opinions when new information becomes available (Elder & Paul, 1994). Cognitive complexity has been linked to the following:

- More flexibility in counseling methods.
- More empathic communication. (Benack, 1998)
- Less prejudice.
- More multicultural appropriateness.
- More sophisticated description of clients.
- More confidence.
- Less anxiety and greater tolerance for ambiguity. (Jennings & Skovholt, 1999)
- More focus on the therapy process and less on the self. (Birk & Mahalik, 1996)

Ridley, Mollen, and Kelly (2011) commented that expert counselors show this cognitive complexity by virtue of their ability to have superior counseling skills (skills of listening, reflecting, and empathy), and an ability to engage in metacognition. Metacognition involves a deliberate effort to examine the self, reflect, and evaluate the process of counseling—not so much from a theoretical perspective but rather from a process perspective. While metacognition leads to specific problem-solving, it evolves beyond a particular task or subject to becoming a way of approaching all life concerns. Metacognition is the differentiating quality between intelligence and wisdom. Wisdom has consistently been differentiated from intelligence (social,

emotional) in research studies (Stenberg, 1985, Sternberg, 1990). Metacognition and wisdom work in unison and support each other rather than being oppositional forces. Thus, a therapist needs both intellectual understanding and wisdom (affective, reflective) to understand and help a client well.

Problem-solving, which is often associated with the job of a therapist, entails one of the cognitive real-world skills associated with wisdom. Judgment is also a complicated skill for therapist—the ability to know when and how to give feedback to a client. Wisdom bearers have been shown to have exceptional expertise in delivering wise judgments. Another aspect that assists therapists in problem solving is tolerance for ambiguity and uncertainty. The capacity to stay in a state of not-knowing with the client helps facilitate clients discovering their own wisdom and unique problem solutions. This capacity to tolerate ambiguity in therapy sets the stage to invite the client to explore their own ambiguity—to address it and deal with it. Bordin (1955), when talking about the therapeutic relationship, said there are three ways that therapists address ambiguity in their sessions: the topics chosen to discuss with clients, the expected closeness of the relationship (the therapeutic frame), and the therapist's values, in terms of setting the goals that the client and therapist should work toward.

By allowing ambiguity, the therapist tackles an urge to be reductionist, gives an opportunity for transference phenomenon to occur, and in that, leads to better interpretations. Bordin (1955) goes on to relate the ambiguity attitude with the Rogerian quality of nonjudgmental attitude, which is a necessary skill for therapists.

Dialectical reasoning, which is associated with wisdom, represents another cognitive characteristic often associated with therapists. Relativism is the ability to contextualize

knowledge and see all knowledge as context dependent. Relativism, in addition to dialectical reasoning, has often been seen as the hallmark of wisdom (Kramer, 2000). Engaging the skills of relativism and dialectical thinking encourages recognizing of context and individuality; it fosters empathic strategies for interpersonal interaction and a recognition of possibilities for change through the integration of affect and cognition (Kramer, 2000). Kramer further stated that therapists need to be aware of and transcend their projections before they can develop both the empathic skills and the cognitive processes associated with wisdom. Personal therapy, supervision, and ongoing training could be a way for wisdom development in therapists.

In their review, Farber, Manevich, Metzger, and Saypol (2005) indicated that practicing therapists generally had high levels *of intellectual curiosity,* had a need to understand others, and were psychologically minded (i.e., insight oriented). Farber et al. also found that most therapists had mentors who guided them in this path. This reflects the wisdom-facilitative environment (Berlin model of wisdom) for expertise in wisdom. Being in situations dealing with difficult life issues and having mentorship was considered wisdom-facilitative. Mentorship may also be a mediating variable in the successful development of competent clinicians.

Parallels in the Wisdom Field and Psychotherapy in the Context of the Affective Dimension

One of the key attributes or components of wisdom is the skill of emotional regulation, also referred to as affect management in therapy literature (Ardelt, 2003). Empathy and compassion are key attributes of therapeutic practice and arise from reflecting on others and reflecting on the process of therapy. Self-reflection, reflectivity, or continuing professional reflection consists of deliberate inquiry to understand the therapy process, as encountered by a

therapist in their professional work (Skovholt, Rønnestad, & Jennings, 1997). Self-reflection leads to a lessening of self-centeredness and increases compassion and sympathy for others. This affect sensitivity and emotional regulation is a key identifier of a wise person (Achenbaum & Orwoll, 1991; Clayton & Birren, 1980; Csikszentmihalyi & Rathunde, 1990; Holliday & Chandler, 1986; Kramer, 1990; Levitt, 1999; Orwoll & Achenbaum, 1993; Pascual-Leone, 1990). Self-reflection is similar to the concept of emotional intelligence, which determines self-awareness and self-management as a foundation for social intelligence (Goleman, 1995). Salovey and Mayer (1990) define emotional intelligence in terms of the "ability to know one's emotions (self-awareness), manage emotions: motivating oneself; recognizing emotion in others (*empathy*) and skill of handling relationships" (p. 189). Kunzman and Baltes (2003) found that wise people did not show extreme happiness, but neither did they show extreme sadness. In their study, wisdom was related to *higher affective involvement* and a *curiosity* to know the other. They concluded that wisdom involved *emotional regulation* along with reflectivity and an understanding of complexity.

Empathy and being aware of one's emotions and emotional responses to the client are key skills in a therapeutic relationship. As a therapist, a lack of awareness of one's emotions leads to complicated countertransference, which if left unaddressed, could lead to therapeutic alliance ruptures. Research has identified that if therapists can manage their own emotions (especially negative emotions) it benefits the therapeutic relationship (Castonguay & Beutler, 2006). Rogers (1957) posited that counselor's positive feelings toward the client is foundational to a good working relationship. The identification, validation, and expression of feelings are central to the therapy process. Empathy, in the process of therapy, increases the possibility for

change. Empathy has consistently been shown to be related to positive outcomes (Elliott, Bohart, Watson, & Greenberg, 2011). In a meta-analysis across diverse orientations and patients, empathy had a significantly medium effect size (Elliott et al., 2011). Castonguay and Beutler (2006) suggested that therapists' attitudes and abilities to show empathy, caring, warmth, acceptance, congruence, and authenticity help to promote a positive working alliance.

Parallels in the Wisdom Field and Psychotherapy in the Context of the Reflective Dimension

Continuous self-reflection and self-awareness have been reported as critical to the therapeutic relationship (in particular) and therapist development (in general; Fauth & Williams, 2005; Skovholt & Jennings, 2005; Skovholt & Rønnestad, 2003). Skovholt and Jennings (2005) succinctly commented, "One ingredient for turning experience into expertise is self-reflection" (p. 15). Ardelt (2003) described reflectivity as the base skill, which helps raise the level of cognitive and affective judgment to wisdom. According to Webster (2007), what characterizes wise people is an attitude of openness to alternate views, information, and potential solutions while exploring possibilities, listening to different viewpoints, and investigating new approaches to problem solving.

Self-reflection also means accepting not-knowing, a willingness to question what is known, and accept that there are limits to knowing (Baltes & Smith, 1990). The future is never fully predictable and not all aspects of the past or present can be known. This quality could be useful for therapists to help the client move on when therapists are stuck in looking at the same problematic solutions to past problems. Self-reflection also builds-in a necessary level of humility in what one knows and fosters a continual interest in learning more (Brown & Greene,

2006). Learning and change can occur when one can reflect on the limitations of knowledge, recognize limitations, and demonstrate an openness and willingness to learn. Castonguay and Beutler (2006) identified, "the therapist is likely to increase his/her effectiveness if he/she demonstrates attitudes of open-mindedness, flexibility, and creativity" (p. 358).

Reflectivity is the key that helps people pause and think, observe, and risk change. Reflectivity for the therapist involves becoming aware of the patterns of transference and countertransference. This means being tuned to the feelings of stuckness and flow in the work with clients (Orlinsky & Rønnestad, 2005). With the client, it helps to bring the unconscious patterns under scrutiny and curiousness with the client about the reason why these patterns exist, the purpose these patterns serve, and what may interfere with the client's changing these patterns. Reflectivity is also a key skill that the therapist must have to invite the client to be curious about their interpersonal dynamics in the alliance. If alliance serves as the vehicle for change then reflection on the alliance gives the vehicle movement. *Deautomatization*, a concept similar to reflection, is defined as the resistance to the tendency to choose the shortest, most used, easiest heuristic in thinking, to which humans are predisposed. B. F. Skinner called this heuristic conditioning—or what is more routinely identified as habits. Automation leads people to do the same behavior, thought, and action again and again; sometimes expecting different results. Sternberg (1990) said that a wise person resists automatization and seeks to understand it in others.

Parallels in the Wisdom Field and Psychotherapy in the Context of the Relational Dimension

The cognitive, affective, and reflective come together in therapy with the therapeutic relationship—which has also been referred to elsewhere in this paper as the working alliance. The relationship is the *what* and *how* of therapeutic work. Psychotherapy, as seen by a majority of orientations, rests on the navigation of the client-therapist relationship. "Techniques and therapy relationship are entwined and any hard-and-fast distinction between them is untenable" (Norcross, 2002, p. 12). Gelso and Carter (1985, 1994) operationally defined the client-therapist relationship as ". . . the feelings and attitudes that therapist and client have towards one another, and the manner in which these are expressed" (Norcross, 2002, p. 7). This working alliance becomes the crucible for change. A therapeutic alliance consists of tasks and goals (i.e., the more cognitive aspect), which are mediated by the therapist-patient emotional bond (Bordin, 1979). Orlinsky and Rønnestad (2005) explored the contribution of the *person* of the therapist to the alliance under three broad headings of relational agency, relational manner, and personal affective responsiveness in-sessions. Relational agency refers to a therapist's experience of their own agentic qualities in working with clients. In-session responsiveness includes the feelings that therapists experience in session; for example, engrossed, inspired, challenged. Relational manner refers to the therapists' ways of relating to a client on a person-to person manner; it is the purely interpersonal context of the therapeutic work. Examples of these individual traits include warmth, nurturance, detachment, and acceptance. Orlinsky and Rønnestad sampled 5,000 therapists and found 80% of the therapists perceived themselves to be committed, involved, and intuitive in working with clients. More than 80% described their relational manner as accepting,

tolerant, warm, and friendly. Engrossed and inspired were the most commonly endorsed terms in-session feelings.

Recent studies have focused on therapists' facilitative interpersonal skills (FIS) and their influence on clients. Increasing evidence points to the role of FIS in causing differences in client outcomes in therapy (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Anderson et al., 2015; Anderson et al., 2016; Schöttke, 2016). Facilitative interpersonal skills represent a composite of relational skills (some of which are warmth, persuasion, empathy, and capacity) to enter into an alliance. Research is still needed to clearly demarcate how the process works in terms of the mechanics of the use of FIS and how it interacts with technical competence and client symptom history.

Wisdom literature has been very consistent in talking about the role of FIS, sociability, proper interpersonal skills, warmth, humor, kindness, and compassion as characteristics of wise men and women (Bluck & Glück, 2005; Holliday & Chandler, 1986; Jason et al., 2001). Research on implicit theories highlight the role of high interpersonal competence in a person being seen as wise in the general population (Baltes & Staudinger, 2000). The social nature of wisdom is also consistently highlighted in the development of wisdom and the performance of wisdom.

In summary, it is evident that expert therapists and wise people have similar personality characteristics of flexibility, openness, comfort with ambiguity and not-knowing, a willingness to question status quo, and occasionally, a well-developed sense of humor. Expert therapists and wise people have high levels of cognitive complexity and curiosity; both are emotionally similar in their ability to self-regulate and have high levels of empathy, acceptance, and compassion. In

addition, expert therapists and wise people also share expertise in self-reflection. These similarities raise the possibility of wisdom being another lens to view psychotherapist development, expertise, and effectiveness. However, at no point is the assumption being made that the mere presence of these characteristics in a person or an expert therapist will be sufficient for them to be wise. The alchemy happens in the blending and coming together of these skills at a particular time with a particular client—"orchestration" as the Berlin group called it (Baltes & Staudinger, 2000, p. 127). This orchestration brings together the personality factors, the skills, the experience, and the social-contextual factors creating the potential for a person or performance to be judged wise. The research fields of wisdom and therapist factors in psychotherapy have evolved and grown more nuanced in parallel. As a result, this current research empirically evaluated the therapeutic practice and personal characteristics of therapists who perceive they are wise with clients.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

Wisdom in therapists has been explored empirically in only a handful of studies (Hanna & Ottens, 1995; Levitt & Piazza-Bonin, 2014; No, 1993; Osterlund, 2011). Most of these studies employed qualitative analysis in efforts of understanding the characteristics involved in naming a therapist as wise using data generated by experts in the field. This study adds to this limited knowledge by using quantitative analyses of therapist-generated data to explore two related aspects of clinical wisdom: (1) wise therapeutic practice, as described by therapists who see themselves as being more or less wise in dealing with clients, and (2) the professional and personal characteristics of therapists who seem to typify this clinical wisdom. This study further expanded on prior research by using a large sample of data from practitioners of different professions, theoretical orientations, career levels, and nations.

Research Questions

The specific research questions this study addresses are as follows:

I. What differentially characterizes *therapeutic practice* for therapists who see themselves as *more* or *less* wise with clients? Drawing on information collected with the DPCCQ, the two aspects of practice examined are:

   A. Technical-instrumental aspects of practice

      1. treatment goals (aims of practice)
      2. clinical skills (implementation of aims)

3. difficulties in practice (difficulties encountered in implementation of aims)
4. coping strategies (strategies for coping with difficulties in practice)

B. Interpersonal-affective aspects of practice

1. frame and boundary management (norms and limits of the therapist role)
2. relational manner (style of relating to clients)
3. therapist's feelings in the therapy session (therapist's personal affects regarding clients *within-session*)
4. therapists' inter-session experiences about patients (therapist's thoughts and affects regarding clients *between-sessions*)

II. What are the distinguishing characteristics of therapists who perceive themselves as being Wisest with clients? Therapist characteristics described in the DPCCQ include:

A. Professional characteristics

1. career level (years in practice)
2. experienced career development to date
3. professional identity
4. theoretical orientation
5. training and supervision
6. personal therapy (utilization and experienced benefit)
7. experienced current development

B. Personal characteristics

1. wisdom in close personal relationships

2. therapist age and sex
3. therapist marital and parental status
4. therapist quality of life (positive and negative) and emotional well-being
5. nationality

Instrument

The *Development of Psychotherapists Common Core Questionnaire* (DPCCQ; Orlinsky et al., 1999) was used to collect information on the personal and professional characteristics of psychotherapists in the International Study of the Development of Psychotherapists (ISDP). Appendix A details the sub-scales of the instrument used for this research, which was a product of an 18-month joint effort by an international group of researchers and psychotherapists of many orientations and professional backgrounds in medicine, psychology, and social work. The DPCCQ is a self-administered, mainly structured-response format tool that takes about an hour to an hour and a half to complete. The standard version of the instrument has 396 items that measure therapists' professional and personal characteristics. The DPCCQ has been translated in over 20 languages and adapted several times to suit a particular country or population. Various dimensions of the therapist's personal and professional life have been studied using this dataset (see Appendix B for a list of publications using the DPCCQ). There are no published studies from this data on the construct of wisdom (clinical and interpersonal) in psychotherapists, as measured by the DPCCQ. Table 5 summarizes the sections of the DPCCQ used in this study.

Table 5. Independent Variables and Associated Questions in the DPCCQ with Scale Measures

Variable	DPCCQ Question	DPCCQ Item	Scale Measure
Personal demographic variables	Age, sex, professional identity, and time since you first started practice.	1.2, 1.3, 1.4, 1.5 to 1.14, and 1.15	Years and months
Theoretical orientation	How much is your current counseling practice guided by each of the following theoretical frameworks?	1.16 to 1.23	0 to 5 (0 = not at all to 5 = very greatly)
Case supervision	Have you received supervision? If yes, how many years and months? Are you currently receiving supervision? How many counselors have sought you out to be their counselor? How many counselors have you supervised in counseling work?	2.10, 2.11, 2.17, 2.18	Years and months
Skill	Overall, at the present time, how effective . . .	5.18 to 5.26	0 to 5 (0 = not at all to 5 = very greatly)
Single factor of skillfulness	A single measure of skillfulness was made by combining. . .	5.18 to 5.26	
Quality of life	How much satisfaction do you feel in your current work as a counselor and How much dissatisfaction do you feel in your current work as a counselor? In your own life at present, how often do you feel . . .	5.19, 5.20 and 12.2 to 12.22	0 to 5 (0 = none to 5 = intense)
Goals in therapy	In your current work as a counsellor how important do you think it is for most clients to realize the following goals?	5.1 to 5.17	Mark 4 most important
Frames (boundaries)	With clients how often do you . . . ?	7.22 to 7.31	0 to 5 (0 = never to 5 =very often)
Relational manner	How would you describe yourself as a counselor…your actual style or manner with clients?	4.15 to 4.38	0 to 3 (0 = not at all to 3 = very much)
In-session feelings	Recently in sessions how often have you found yourself feeling..?	7.13 to 7.28	0 to 3 (0 = not at all to 3 = very much)
Difficulties in practice	Currently, how often do you feel . . . ?	6.1 to 6.18	0 to 5 (0 = never to 5 = very often)
Coping strategies	When in difficulty, how often do you . . . ?	6.19 to 7.6	0 to 5 (0 = never to 5 = very often)

Operational Definitions (based on Orlinsky & Rønnestad, 2005)

The dependent variables for this study are defined operationally as follows:

Clinical wisdom: One item from the DPCCQ asked therapists to rate the question, *How would you describe yourself as a therapist—your actual style or manner with clients*, on a 4-point scale ranging from 0 = Not at All to 3 = Very Much Wise (which was the last among 24 adjectives that followed this question in alphabetical order). The section's intent was to explore the relational agency of the therapist. Factor analysis of these items yielded the following three dimensions:

1. Invested
2. Efficacious
3. Baffled

For the purpose of this study, the dependent variable has been used as a 4-point scale for most analysis—the exception being while studying psychotherapist's goals where therapists had to mark 4 out of 16 goals. For the analysis of goals, a binary variable wise was created from the 4-point clinical wisdom scale. Therapists who marked themselves as 2 (Much Wise) or 3 (Very Much Wise) were combined into one category as Wise Therapists. Therapists who marked themselves as 0 (Not at All Wise) and 1 (Somewhat Wise) were combined into a single category of Not-Wise Therapists.

Independent variables for this study include the following information from the DPCCQ regarding therapists' experiences of clinical practice and characteristics as practitioners. Practice variables include:

Treatment goals: Treatment goals define the strategic focus of therapeutic work as well as the criteria for evaluating its success. The treatment goals section has 16 items representing the top goals of most theoretical orientations used in psychotherapy. Therapists marked any four that were generally the most important to them in their practice.

Clinical skills: The clinical skills section asked therapists to rate the clinical skills they perceive themselves to have and use in their current practice on a 6-point scale. The initial factor analysis of the items on therapeutic skills yielded three intercorrelated dimensions:

1. Technical expertise skills
2. Basic relational skills
3. Advanced relational skills

Technical expertise skills deal with the understanding and application of the theory of therapy and mastery of the techniques and strategies of the practice of therapy. Basic relational skills include empathy across clients, effectiveness in engaging clients in a therapeutic alliance, and efficiency in grasping the core of the patient's problems. Advanced relational skills speak to the nuanced and subtle skills of using the self of the therapist in working with the alliance. In psychoanalytic terminology, these advanced relational skills include the understanding and management of transference and countertransference phenomenon.

Difficulties in practice: Items in this section were based on the qualitative research of Davis, Francis, Davis, and Schroder (1987) and refer to the various difficulties therapists encounter in their practice. Factor analysis of the 26 items in this section yielded three dimensions of difficulties:

1. Professional self-doubt

2. Frustrating treatment case
3. Negative personal reaction

The first dimension deals with the therapist feeling unsure on how best to deal with a patient or feeling a lack of confidence in one's ability to have a beneficial effect on a client. The second dimension relates to the distress experienced over a patient's tragic situation or feeling bogged down by the circumstances in the patient's life. The last dimension deals with the therapist's inability to find something to like or respect in a client or to withstand a patient's emotional neediness.

Coping strategies: When difficulties arise, therapists (intentionally or unintentionally) rely on coping strategies, some of which may or may not be helpful. This section in the DPCCQ is based on the qualitative study by Davis et al. (1987) who formulated 13 coping strategies based on reports by therapists. The coping strategies section has 26 items rated on a 6-point scale. Factor analysis of these 26 coping skills led to six dimensions:

1. Exercise reflective control
2. Seek consultation
3. Problem-solve with patient
4. Reframe the helping contract
5. Seek alternate satisfactions
6. Avoid therapeutic engagement

These factors were later combined to give two higher-order factors:

1. Constructive coping
2. Avoiding therapeutic engagement

Relational manner: This entailed the actual style or manner of working with patients, which helps in the creation and maintenance of a therapeutic relationship. Relational manner refers to the aspect of a therapist's work that contributes to the therapeutic *bond* (Bordin, 1979; Orlinsky & Howard, 1987). These show the personal characteristics of the therapist that engage with those of the patient. The question on relational manner is answered by rating a series of adjectives suggested by the circumplex model of interpersonal behavior developed by Leary (1957). Factor analysis of the 28, 4-point Likert scale items yielded four dimensions:

1. Affirming style
2. Directive
3. Effective
4. Reserved

Therapist in-session feelings: This represents the feelings of therapists as they work with patients in therapy sessions—reflecting the therapist's personal response to the complexity of therapeutic work. Items for this section are drawn from the work of Csikszentmihalyi (1990, 1996) on optimum experience and intrinsic motivation. The three subjective states that he speaks about are: anxiety, boredom, and flow. Four scales measure each of these three states in the DPCCQ. These 12, 4-point Likert scale items in this section yielded three affective states (anxiety, boredom, flow), as posited by the theory in which they were derived.

Therapist inter-session feelings: Therapist inter-session feelings refer to the feelings a therapist has about his or her client between two sessions. These are measured on the DPCCQ by a scale consisting of five items, which are theoretically drawn from the psychoanalytic concept of countertransference or a form of homework that therapists engage in before meeting their

client again (Schröder, Wiseman, & Orlinsky, 2009). Each of these items is measured on a 6-point scale ranging from 0-5, where 0 = Never and 5 = Very Often. The question, *In the last few days outside of sessions, how often have you found yourself . . .”* was asked and followed by the five items related to inter-session experiences of the therapists regarding their clients.

Therapeutic frame and relational boundaries: This section focuses on management of the therapeutic frame and relational boundaries, which comprise the ground rules for therapeutic work. Factor analysis of the 10 items in this section yielded two dimensions (Davis, Schroder, & Orlinsky, 2011):

1. Frame flexibility
2. Boundary laxity

The personal and professional characteristics of therapists used as independent variables in this study include personal and professional characteristics.

Personal characteristics consisted of the following:

- Age, measured in years and months as a continuous variable.
- Sex, self-identified by respondents to the DPCCQ as male or female.
- Nationality, refers to the country the therapist resides in at the time of completing the DPCCQ. An additional question asks the therapist’s status as native or immigrant to the country in which he or she resides, which was not considered in this study.
- Marital status, seven alternatives are considered: single (unattached), single (in a relationship), living with a partner, married, separated or divorced, widowed, and remarried (after divorce or widowhood).

- Parenthood, assessed by asking if the therapist has children. Further details about number of children are also assessed by the DPCCQ but were not studied in this research.
- Wisdom in close personal (intimate) relationships: One item from the DPCCQ asked therapists to rate the question, *How would you describe yourself in your close personal relationships* on a 4-point scale ranging from 0 = Not at All to 3 = Very Much. *Wise* was one of the options from 28 adjectives that followed this question.

Professional characteristics consisted of the following:

Career level: Career level is defined in terms of years since the therapist first began practice (saw their first real client). Past research with this data has often divided the sample into six career cohorts based on literature on supervision and the clinical experience of the SPR/CRN team. This study used the same process.

Experienced career development: Experienced career development refers to the therapist's overall experience of development as a professional therapist from when he or she entered the profession (saw their first real client) to the present day. This is assessed by asking therapists to reflect on their careers and judge how much and in what direction their professional life has developed. Four questions in the DPCCQ ask therapists how much they have changed overall since beginning their practice and if they view this change positively or negatively. In addition, past studies have also used high levels of mastery in technical expertise and advanced relational skills when assessing therapist's experience of their own development across their professional career. For the present study, the set of four direct questions and the two indirect questions just stated were used.

Experienced current development: Refers to the therapist's present ongoing experience of transformation (either improvement or impairment) in contrast to a stable, unvarying sense of therapeutic functioning. This sense of current development was assessed by 10 direct questions asking therapists about their overall development. Factor analysis of responses to these 10 items yielded two factors in the past: a positive factor showing vigorous progress called currently experienced growth and a negative factor showing dullness and erosion called currently experienced depletion.

Professional identity: Professional identity refers to the profession in which the therapist trained as a gateway to clinical practice. Psychotherapy is practiced by many professionals with different training backgrounds. Psychiatrists practice psychotherapy as do social workers, counselors, and clinical psychologists. Professional background was assessed by asking nine professional backgrounds and one open-ended option for professionals to write down professional identities besides the nine in the DPCCQ. Therapist's answering the DPCCQ could mark as many options as applicable to them.

Theoretical orientation: Theoretical orientation was assessed by asking therapists to rate, on a 6-point scale, how much each of the five different theoretical orientations influenced their practice. The five options were: analytic-psychodynamic, behavioral, cognitive, humanistic, and an open-ended response for others. A reliable scale was also constructed for Cognitive-Behavioral orientation as the mean value of the separate behavioral and cognitive scales. Because the therapists could rate several scales differently, it is possible to construct different profiles of therapists who endorse certain orientations as salient (i.e., 4 or 5 on the 0-5 scale), either as single salient orientations or in combinations with other salient orientations.

Training and supervision: The DPCCQ has items that ask about academic degrees, additional psychotherapy training, and amount of supervision received (amount of supervision in the past and if currently in supervision). An additional item assessing if the therapists had provided supervision to other therapists was included. If therapists responded Yes to this item, they were then asked for a range of the number of therapists they had supervised: 1-3, 4-9. 10-15, 16-14, and more than 25.

Personal therapy: The DPCCQ collects information about the type, frequency, duration, and personal value of the therapist's own personal therapy including multiple courses of personal therapy.

Emotional and psychological well-being: Emotional and psychological well-being is assessed by one item that asks therapists to describe their present state of emotional and psychological well-being. This question is followed by six options ranging from Quite Poorly Managing to Managing Very Well.

Quality of life: Encompasses a set of 11 questions assessing levels of satisfaction with intimacy and emotional support; stress and anxiety about wealth, health, and relationships; and therapist's self-care.

Nature of Self-Reports

Getting information from therapists on such a wide range of personal and professional characteristics could be obtained from other means (such as interviews and observation). However, this group of researchers deemed that the best starting point involved distributing a survey of self-assessment (Orlinsky et al., 1999). This was done for three reasons: (a) self-reports constituted essential data, particularly in understanding the psychotherapists' current and

retrospective development as clinicians, (b) surveys represented a more affordable approach (allowing for a greater wealth of information without requiring external funding), and (c) therapists-led studies promoted an attitude of which allowed psychotherapists to feel more akin to colleagues sharing their experiences for the purpose of research rather than feeling like scrutinized subjects.

Self-reports remain one of the most widely used means of collecting data in the behavioral sciences and also one of the most criticized (Haeffel & Howard, 2010). The use of self-reports with psychotherapists is less contentious as, "Therapists generally are trained and disposed to reflect constructively on their motives and behaviors (Skovholt & Rønnestad, 1995), and may in fact be relatively objective in such self-evaluative tasks" Orlinsky et al. 1999 (p. 133). The classic article by Nisbett and Wilson (1977) cited the drawback of this method, including the lack of insight people have into their own cognitive processes (e.g., motivations) and susceptibility to what is expected from them, typically, in certain situations. What the critics fail to mention is that Nisbett and Wilson did not discredit self-reports completely, but said humans can validly report (superior to observations) a host of personal facts such as information on emotions, attention, evaluations, and plans; yet, there are limits of introspection as it is influenced by conscious and unconscious motives (Wilson & Dunn, 2004). Self-reports are useful in getting information on moods, behaviors, and psychopathology. In fact, self-report measures often outperform other measurement techniques in terms of predictive power (Haeffel & Howard, 2010).

The main criticisms of self-reports include image management, intentional positive self-presentation, and inaccuracy of people's self-judgment. It seems it would be problematic to ask

research participants to rate their own degree of wisdom directly (e.g., on a scale ranging from 0 = Not Wise at All to 3 = Extremely Wise) because wise people typically know they still lack wisdom, whereas less wise people might be under the illusion (or delusion) that they are wise. Hence, assessing wisdom through a scale might be only partially successful (Jeste et al., 2010). Assessing wisdom through life task vignettes, as used by the Berlin Wisdom and Bremen Wisdom researchers (Mickler & Staudinger, 2008, p. 43), is lengthy, expensive, and very dependent on language and the cognitive abilities of the participants. Thus, all methods have their advantages and disadvantages when it comes to studying a positively valued social concept such as wisdom—especially among the therapist population. The assumption, which may be erroneous, is that therapists will be more objective and self-perceptive given their training and the nature of their work on the following issues:

1. Issues of honesty/image management. Wisdom, as a value, has a positive valence and most people want to possess or feel in some way associated with the word. It would be interesting to see how therapists, who are supposed to be high performers on wisdom-related tasks (Smith, Staudinger, & Baltes, 1994; Staudinger, Smith, & Baltes, 1992) respond to this question. This study pinpointed therapists who answered this question in the affirmative (as well as those who stated they are Not Wise at All) and examined the differences. In this way, the issue of image management is included as a topic to be explored via the study design.
2. Ability to introspect. The ability to introspect and reflect presents a unique challenge when studying wisdom in participants. The more one reflects, the more aware he or she becomes of the limits of one's knowledge and hence, more self-critical. In fact,

this knowledge may lead truly wise people to give themselves a very low rating on wisdom (Aldwin, 2009; Assman, 1994). According to Walfish, McAlister, O'Donnell, and Lambert's (2012) article on self-assessment bias in mental health providers, clinicians not only appraise themselves very positively but also hardly any therapists viewed themselves as below average.

3. Understanding and interpreting the question. To understand and interpret the question in the manner the researcher intended is especially pertinent when discussing abstract constructs such as wisdom. In a field where researchers are still evolving a common and well-accepted definition of wisdom, this issue could be a possible source of discrepancy. Respondents answer a question based on their own idiosyncratic understanding of the concept, which could cause discrepancies in the data collected. However, given that most people recognize wisdom when they see it, it may be there involves some common notion about wisdom in the implicit theories of wisdom people have (Baltes & Staudinger, 2004).

Sample

A total of 4139 therapists answered the question regarding Feeling Wise with clients. The sample size for the current study represents a smaller size than the total data set collected as a part of the ISDP as the items on wisdom are present only in the most recent versions of the questionnaire.

Data from which the sample for this study was drawn were collected from over 11,000 psychotherapists with 25 countries represented by more than 100 therapists as a part of the Society for Psychotherapy Research Collaborative Research Network (SPR/CRN), ISDP. The

researcher is a member of the SPR/CRN and has contributed to this dataset in the past by collaborating in the collection and analysis of data from psychotherapists in India. Permission to use the dataset for this study has been granted from the SPR/CRN Steering Committee.

The reason for using an existing source of data or conducting a secondary data analysis is that ISDP is one of the largest studies on development of psychotherapists internationally. The breadth and depth of therapist variables that it studies is enormous. In addition, the study is updated continuously with new variables added, yielding newer versions. The ISDP's validity and reliability have been demonstrated and many published studies exist using this dataset. Using a subsample from this dataset maximizes the potential for a large sample for the current study. The large sample size also provides statistical power for data analyses. However, as with any secondary dataset, there are potential disadvantages—one being that the data has already been collected. Using a secondary dataset limits the study of the variable of interest as that was only one of many items in which respondents replied. In the current study, a rigorous process of developing the theoretical frame was undertaken to make sure that a strong conceptual grounding guided this research.

Therapists in the ISDP were recruited between 1991 and 2012 by the researchers who participated in the SPR/CRN. Psychotherapists were approached by various means and invited to participate in this research—e.g., from professional workshops and conferences, professional societies and therapist training programs, individual collegial networks, telephone directories of providers of counseling or therapy services, and randomized samplings of professional societies. The ISDP has led to a database of nearly 12,000 therapists of different theoretical orientations,

career levels, backgrounds, professions, and nationalities. The ISDP participation has always been voluntary and does not offer financial incentives for a psychotherapist's participation.

Sample Characteristics

The sample consisted of 4139 therapists (70% women, 30% men) with ages ranging from 21-97 years (M = 50.5, SD =11.04) from 12 countries. The therapists had, on average, 14.2 years of experience. Table 6 outlines further details regarding the sample of therapists:

Table 6. Sample Characteristics of Self-Perceived Wise Therapists

Therapist Characteristics	N	%
Professional Background		
Psychology	1606	38.9
Psychiatry	160	3.9
Counselling	1502	36.3
Social Work	201	4.9
Therapist/Analyst	348	8.4
Nursing	189	4.6
Other Professions	120	2.9
Practice Duration (in years)		
Mean (SD)	14.19 (*9.8*)	
Range	55	
Career Level		
0 to 1.5 years	121	3
1.5 to < 3.5	291	7.1
3.5 to < 7 years	676	16.6
7 to < 15 years	1319	32.4
15 to < 25 years	1017	25
25 to < 55 years	648	15.9
Salient Theoretical Orientation[a]		
Cognitive	1343	32.4
Behavioural	899	21.7
Systemic	997	24
Humanistic	1497	36.2
Analytic/dynamic	1539	37.2

Nationality		
UK	981	23.8
Australia	982	23.8
USA	694	16.8
Denmark	362	8.7
New Zealand	321	7.8
Canada	268	6.5
Chile	144	3.5
Malaysia	109	2.6
Ireland	97	2.4
Slovakia	78	1.9
Mexico	62	1.5
Turkey	27	.7
Total	4139	100.0

[a] Saliency is measured as a response of 4 (Greatly) or 5 (Very Greatly) to the question, *How much is your current therapeutic approach guided by the following theoretical frameworks*? Respondents could mark as many theoretical orientations as applicable to their development.

Data Analysis

Validity, Reliability, and Generalizability of the DPCCQ

The DPCCQ is a broad-ranging survey of psychotherapists' experiences and characteristics from which various specific measures can be constructed. The size and heterogeneity of the SPR/CRN allow for data analyses with strong internal validity. Tentative hypotheses regarding generalizability of findings have been made through a variety of means. For example, by including detailed descriptions of therapists' backgrounds, findings from this sample can be cautiously generalized to other psychotherapists with similar characteristics. The DPCCQ contains specific questions that are interesting in their own right and then tabulated using standard measures of central tendency, variability, and percentages of endorsement.

In addition to these first-level analyses of separate sections of the DPCCQ, psychologically meaningful dimensions were constructed through further analyses of first-level factors (Orlinsky & Rønnestad, 2005). Researchers have used factor analysis to determine underlying meaningful dimensions found within this rich data. Item responses were

intercorrelated and, through principal-component analysis, factors were extracted from the correlation matrix. Finally, the Varimax method was used to rotate the resulting factors. The stability of the factor solution was checked and multi-item scales using those items with loadings of 0.35 were created. Testing for reliability (internal consistency) was done using Cronbach's alpha. Rasch analyses was also used for key scales. The results of those tests are published in various studies (e.g., Orlinsky & Rønnestad, 2005; Orlinsky et al., 1999; see Appendix B) and reported at SPR conferences. Both face and concurrent validity have been established for these scales by demonstrating their meaningfulness and their association with other variables. The structure of the questionnaire and large sample size lend themselves well to a descriptive quantitative design.

To answer the research questions, the data was checked for missing values. Some observations were missing because one, different versions of the questionnaire were used in different rounds of data collection and two, it was not mandatory to answer each question. It is possible that some therapists skipped some items intentionally or unintentionally. Missing data was checked to see if the errors were random or nonrandom. Once it was established that the errors were due to chance and the sample size was still adequate, the analysis was performed using the following described method.

The first level of analysis involved computing descriptive and bivariate data to explore the data and identify potential outliers. Continuous measures lend themselves well to correlational and regression analyses; categorical variables were analyzed with the Chi-square statistic. When both types of variables were involved, one-way or more complex analysis of variance models were used. Assumptions for Chi-square (including independence of data and

making sure that expected frequencies were always greater than five in each cell), were duly checked before proceeding with further analysis.

In addition to the Chi-square statistic, the standardized residual was used to interpret the results of the Chi-square test. To compute the differences between group means for categorical variables (in relation to self-perceived clinical wisdom), analysis of variance (ANOVA) was used. The assumptions of independence of observations, normality, and homoscedasticity were checked before conducting ANOVA. The F-statistic so generated was utilized to understand model fit and differences among groups. For the items where the F-statistic was significant, post hoc tests such as the Scheffe method was used to further analyze differences among the groups. The Scheffe method was selected for post hoc analysis as it is the most conservative of the post hoc tests and had the ability to make more than pairwise comparisons.

CHAPTER FOUR

RESULTS—PRACTICE CORRELATES

This cross sectional study examined the practice and practitioner characteristics of therapists who perceived they were wise with their clients. Therapist data for this study was collected by a group of researchers of the Society for Psychotherapy Research (SPR) called the Collaborative Research Network (CRN) using the Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky et al., 1999) for the International Study on the Development of Psychotherapists (ISDP) over two decades. The items in the DPCCQ pertain to practice and practitioner characteristics of therapists, and are measured as both discrete and continuous scale items. Data from therapists who completed the DPCCQ and answered the question related to, *How Wise do you feel with your clients*, measured on a categorical scale (ranging from 0-3, with 0 being Not Wise at All with clients and 3 being Very Much Wise with clients) was included for analysis in this study. This resulted in a sample size of 4139 therapists. Analysis of their personal and practice characteristics involved descriptive statistics and comparative analyses using one-way analysis of variance (ANOVA) and Chi-squares, as appropriate. Results are discussed in two parts in this study: Chapter Four, which examines the practice characteristics of self-perceived wise therapists and Chapter Five, which examines the practitioner correlates of the wise therapist.

This chapter presents the analysis of the practice variables of the therapists who feel More or Less Wise with clients. The practice variables of therapists have been studied in

previous literature (Orlinsky & Rønnestad, 2005) by categorizing them into two broad dimensions: (a) technical-instrumental factors and (b) interpersonal-affective factors.

The technical aspects of therapeutic work consist of the active work of therapy; for example, setting session goals, skills used to implement session goals, difficulties encountered in the implementation of these aims, and the coping strategies used by the therapists to manage these difficulties in practice. These factors relate to the instrumental or the doing of the work of therapy, which is facilitated by the therapeutic relationship.

The interpersonal-affective factors speak to the way the therapists report managing the therapeutic relationship including the ethical norms and boundaries of the therapist's role (frame and boundary management), the relational manner of the therapist (style of relating to clients), the therapist's feelings in-session regarding the client, and the therapist's feeling and thoughts regarding the client in-between sessions (inter-session experience). The aspects of technical-instrumental and interpersonal-affective factors explored in this chapter follow:

Technical-instrumental aspects of practice

1. Treatment goals (aims of practice)
2. Clinical skills (implementation of aims)
3. Difficulties in practice (difficulties encountered in implementation of aims)
4. Coping strategies (strategies for coping with difficulties in practice)

Interpersonal-affective aspects of practice

1. Frame and boundary management (norms and limits of the therapist role)
2. Relational manner (style of relating to clients or self-in-therapist-role)

3. Therapists' feelings in the therapy session (therapist's personal affects regarding clients *within-session*)
4. Therapists' inter-session experiences about patients (therapist's thoughts and affects regarding clients *between-sessions*).

The first part of this chapter reported the results of the analysis of the technical-instrumental aspects of the practice of therapists who Feel Wise with their clients. This was followed by the section on the results of the analysis of the interpersonal-affective characteristics of therapists who feel More or Less Wise with their clients.

Technical Instrumental Aspects of Practice

The technical-instrumental aspects of therapeutic practice refer to the active work of therapy, the tasks, the goals, the difficulties, and the skills used in the work of therapy.

Treatment Goals (Aims of Practice)

The therapists' treatment goals were assessed by a 16-scale item in the DPCCQ, which represented the top goals of most theoretical orientations commonly used in psychotherapy. Therapists were asked to rate the top four goals (among the 16) that they usually have for their clients in practice. A binary variable of Wise (if 2 or 3 were selected) and Not Wise (if 0 or 1 was selected) was created for statistical analysis to see if the goals endorsed by the Wise and Not Wise were different from each other. The binary variables were created in the SPSS file by collating the responses of the therapists who responded with 0 (Not Wise at All) and 1 (Somewhat Wise) and treating that as a Not Wise response for the analysis of treatment goals of therapists for this study. The responses of 2 (Much Wise) and 3 (Very Much Wise) were collated and treated as a response of Wise for this analysis of treatment goals.

Table 7. Treatment Goals of Self-Perceived Wise Therapists and Not Wise Therapists

Goals	Percentage Endorsed	WISE [a] Mean (*SD*)	WISE [a] Rank	NOT WISE [b] Rank	NOT WISE [b] Mean (*SD*)
Strong sense of self-worth and self-identity.	60%	1.62 (.48)	1	1	1.54 (.49)
Understand feelings, motives, and/or behavior.	48%	1.47 (.50)	2	2	1.51 (.50)
Learn to recognize and change how they create their own problems.	45%	1.46 (.50)	3	3	1.41 (.49)
Improve the quality of their relationships.	37%	1.37 (.48)	4	4	1.36 (.48)
Experience a decrease in their symptoms.	31%	1.31 (.46)	5	5	1.30 (.46)
Think realistically about the meaning of events.	18%	1.18 (.39)	11	10	1.20 (.39)
Allow themselves to experience feelings fully.	24%	1.24 (.42)	6	6	1.23 (.42)
Learn to behave effectively in problematic situations.	19%	1.20 (.40)	8	11	1.18 (.38)
Develop courage.	16%	1.16 (.36)	13	12	1.17 (.38)
Integrate excluded or segregated aspects of experience.	19%	1.19 (.39)	9	7	1.21 (.41)
Modify or control problematic patterns of behavior.	9%	1.19 (.39)	9	7	1.21 (.40)
Evaluate themselves realistically.	11%	1.11 (.31)	14	14	1.10 (.30)
Identify and pursue their own goals.	21%	1.21 (.41)	7	7	1.21 (.41)
Develop a more tolerant attitude toward others.	4%	1.04 (.19)	16	15	1.04 (.19)
Develop better ability to meet important familial and social responsibilities.	3%	1.03 (.18)	16	16	1.03 (.18)
Clarify their overall sense of values.	17%	1.17 (.38)	12	12	1.17 (.37)
Resolve or cope with confusions in cultural ideals and expectations.	5%	1.05 (.22)	15	15	1.04 (.11)

[a] Therapists who responded 2 or 3 to the question, *How would you describe yourself as a therapist,* followed by the option, Wise, on a 4-point scale where 0 = Not at All Wise, 1 = Somewhat Wise, 2 = Much Wise, and 3 = Very Much Wise.

[b] Therapists who responded 0 or 1 to the question, *How would you describe yourself as a therapist,* followed by the option, Wise, on a 4-point scale where 0 = Not at All Wise, 1 = Somewhat Wise, 2 = Much Wise, and 3 = Very Much Wise.

As seen in Table 7, the most endorsed goals of therapists who feel Wise with their clients and those that feel Not Wise with their clients are the same. Namely, helping clients have a strong sense of self-worth and helping clients understand their feelings, motives, and behaviors

were the top two goals endorsed by the self-perceived Wise and the Not Wise therapists alike. Similarly, the least endorsed goals were the same for both the self-perceived Wise and Not Wise therapists.

Clinical Skills (Implementation of Aims)

Another research question involved examining the difference in the self-perceived skillfulness of therapists based on how Wise they felt with their clients. To answer this question, the DPCCQ presented a set of items that asked therapists to rate, on a 6-point scale (where 0 = Not at All and 5 = Very Much), 12 items related to the therapist's skillfulness. Statistical analysis consisted of initial bivariate correlations. All skills were significantly related to self-perceived clinical wisdom and to each other at the alpha =.01 level of significance. This meant that the skills could possibly be combined into a single item scale for skillfulness if adequate reliability could be achieved (as seen from the Cronbach's alpha for internal reliability). Following these results, the F-test (ANOVA) was used to assess significant mean difference between the four groups of self-perceived clinically wise therapists. Scheffe's method was used to look at post hoc comparisons, since this method controls for the overall confidence level and can be used with unequal sample sizes. Table 8 details the results of the ANOVA used to study the relationship between self-perceived clinical wisdom in therapists and skillfulness.

Table 8. Relationship Between Self-Perceived Clinical Wisdom and Skillfulness in Therapists

Skills	***F***	***p***	**Post Hoc Scheffe Test**
Engaging clients in a working alliance?	87.99 (3, 4100)	<.001	**3** > 2 > 0
How natural (authentically personal) do you feel while working with clients?	79.69 (3, 4100)	<.001	**3** > 2 > 0
General theoretical understanding?	61.59 (3, 3733)	<.001	**3** > 2 > 1
Empathic in relating to clients with whom you had relatively little in common?	41.80 (3, 3760)	<.001	**3** > 2
Grasping the essence of patients' problems?	3.09 (3, 202)	.028	**3** > 0
Understand what happens moment-by-moment during therapy sessions?	89.16 (3, 4097)	<.001	**3** >2 > 0,1
Effectiveness in communicating your understanding and concern to your clients?	68.29 (3, 3762)	<.001	**3** >2 > 0,1
Mastery of the techniques and strategies involved in practicing therapy?	99.09 (3, 4093)	<.001	**3** > 2 > 0, 1
Detect and deal with your clients' emotional reactions to you?	12.14 (3, 1675)	<.001	**3** > 1
Making constructive use of your personal reactions to clients?	16.36 (3, 1673)	<.001	**3** > 1
Precision, subtlety, and finesse in your therapeutic work?	144.60 (3, 4065)	<.001	**3** > 2 > 1
Confident in role as a therapist?	120.30 (3, 3727)	<.001	**3** > 2 > 0, 1

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

Table 8 shows that the therapists who perceive that they are Very Much Wise with their clients (who have marked themselves as a 3 on the self-perceived clinical wisdom item) also felt significantly more skillful with their clients than the other therapists. This feeling of skillfulness pertains to theoretical understanding and basic therapeutic skills including confidence in the role as therapist. Given the high interrelation of the skills, in previous studies (Orlinsky & Rønnestad, 2005), factor analysis of the 12 items yielded three, first-order factors: basic relational skills, technical expertise, and advanced relational skills. The therapists who felt Very Much Wise with their clients also felt they possessed higher levels of basic relational skills (e.g., effective in communicating their understanding of the client's problem to the client), technical expertise (e.g., mastery of the techniques and strategies involved in practicing therapy), and advanced-

level relational skills (e.g., being able to make constructive use of personal reactions to clients) than the therapists who feel Somewhat Wise, Much Wise, or Not at All Wise.

The responses on the items that measure skillfulness in this study were significantly highly correlated. All of the 12 items in the scale were then combined to yield a single-item scale of skillfulness. The alpha for the combined scale was found to be .88, which is considered an acceptable level (.9 to .8), to consider this single-item-scale as a reliable measure of therapist self-perceived skillfulness. ANOVA was used to assess if there was a significant difference between the means of the four groups of therapists differing in levels of self-perceived wisdom on the single-item scale of skillfulness. There was a significant difference between the means of the four groups of therapists on a single-item scale of skillfulness F (3, 3368) = 151.91, p <.001. Post hoc analysis with multiple comparisons using Scheffe's method revealed that the group of therapists who perceived they were Very Wise with their clients had the highest mean on the single scale of skillfulness (M = 4.30), which was significantly different (higher) from the therapists who felt Much Wise (M = 4.01); and they were significantly different from the group that felt Somewhat Wise (M = 3.78) or Not at All Wise (M = 3.83).

Difficulties in Practice (Difficulties Encountered in Implementation of Aims)

The next research question examined the differences in difficulties faced by the therapists in practice based on how Wise they felt they were with their clients. Initial bivariate correlations revealed that all the difficulties were significantly negatively correlated with feeling Wise with clients. Difficulties were measured by a 20-item scale related to typical difficulties faced by therapists in practice. The therapists had to respond to each item related to difficulty in therapy practice on a scale of 0-5 where a response of 0 = Never and 5 = Very Frequently. To explore the

relationship between therapists' self-perceived clinical wisdom and difficulties in practice, statistical analysis was conducted using ANOVA and Scheffe's post hoc test. Table 9 presents the results. Table 9 shows that the therapists who felt Very Wise with clients also reported that they had significantly lower amounts of difficulty in practice, as compared to the other groups of therapists.

Factor analysis of the difficulties experienced by therapists in past studies (Orlinsky & Rønnestad, 2005) yielded three stable factors:

1. Factor 1: Frustrating treatment case (combining difficulty 7, 8, 10, 17, 18, 19, 20. Cronbach's $\alpha = .79$)
2. Factor 2: Negative personal reaction to a client (combining difficulty 5, 6, 13, 14, 15. Cronbach's $\alpha = .78$)
3. Factor 3: Professional self-doubt (combining difficulty 1, 3, 9, 11. Cronbach's $\alpha = .76$)

To further explore if a difference existed among the levels of Wise therapists on these subfactors of difficulties, further ANOVA and post hoc Scheffe analysis were conducted. Results are presented in Table 10.

Table 9. Relationship Between Self-Perceived Clinical Wisdom and Difficulties in Practice

Difficulties	***F***	***p***	**Post Hoc** [a]
Lacking the confidence that you can have a beneficial effect on a client.	51.13 (3, 4017)	<.001	**3** <2 <1,0
Afraid that you are doing more harm than good in treating a client.	28.31 (3, 4013)	<.001	**3** <2 <0
Unsure of how best to deal effectively with a client.	38.70 (3, 4016)	<.001	**3** <2 <1,0
In danger of losing control of the therapeutic situation to a client.	19.80 (3, 4017)	<.001	**3** <2<1,0
Unable to have much real empathy for a client's experiences.	13.16 (3, 4018)	<.001	**3** <1,0
Uneasy that your personal values make it difficult to maintain an appropriate attitude toward the client.	10.92 (3, 4016)	<.001	**3** <2<1,0
Distressed by your powerlessness to affect a client's tragic life situation.	7.78 (3, 4016)	<.001	**3** <1
Troubled by ethical issues that have arisen in your work with a client.	9.26 (3, 4013)	<.001	**3** <1,0
Unable to generate sufficient momentum to move therapy with a client in a constructive direction.	17.27 (3, 4015)	<.001	**3** <1,0
Irritated with a client who is actively blocking your efforts.	10.94 (3, 4014)	<.001	**3** <1
Demoralized by your inability to find ways to help a client.	31.72 (3, 4016)	<.001	**3** < 2,0,1
Unable to comprehend the essence of a client's problems.	37.94 (3, 4026)	<.001	**3** < 2,1,0
Unable to withstand a client's emotional neediness.	19.08 (3, 4026)	<.001	**3** < 2,1,0
Unable to find something to like or respect in a client.	6.03 (3, 4029)	<.001	**3** < 0
Angered by factors in a client's life that prevent a beneficial outcome.	4.69 (3, 4014)	.003	N/S
Conflicted about how to reconcile obligations to a client with equivalent obligations to others.	8.31 (3, 4014)	<.001	**3** < 0
Bogged down with a client in a relationship that seems to go nowhere.	19.27 (3, 4014)	<.001	**3** < 2 < 0
Frustrated with a client for wasting the therapist's time.	7.32 (3, 4015)	<.001	N/S

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise/

N/S= Non Significant Difference

Table 10. Relationship Between Self-Perceived Clinical Wisdom and Dimensions of Therapeutic Difficulties

Dimensions of Difficulties	***F***	***p***	**Post Hoc** [a]
Frustrating treatment case.	18.59 (3, 4003)	<.001	**3** < 2, 1, 0
Negative personal reaction.	29.52 (3, 4003)	<.001	**3** < 2, 1, 0
Professional self-doubt.	55.53 (3, 4006)	<.001	**3** <2 <0, 1
Difficulties total (single item scale).	41.33 (3, 3993)	<.001	**3** < 2, 1, 0

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise.

Table 10 shows that therapists who report feeling Very Wise with their clients also reported significantly lower professional doubts, experienced the client as frustrating least frequently, and had the least acute negative personal reaction to the client.

Since all the items measuring difficulties were highly negatively correlated with wisdom and significantly positively correlated with each other, a single-item scale of therapeutic difficulty was constructed combining all the items in the previously analyzed 20-item difficulty scale (except for items 12 and 16). This scale had a reliability value of Cronbach's $\alpha = .83$, which is considered statistically acceptable. To compare the means of the various levels of wise therapists on this single item scale, ANOVA was used and showed a significant difference between the four groups of clinically wise therapists $F(3, 3993) = 41.33$, $p < .001$. Post hoc analysis using the Scheffe test reconfirmed that the group of therapists who perceived they were Very Wise with their clients also reported experiencing significantly least therapeutic difficulties, as compared to the other groups of wise therapists.

Coping Strategies (Strategies for Coping with Difficulties in Practice)

To cope with the difficulties discussed in the Difficulties in Practice section, therapists reported employing a wide variety of techniques. These were measured using the 11-item scale in the DPCCQ and based on the work of Davis et al. (1987). Initial correlations tabulated in Table 11 show that perceived wisdom with clients in therapists was significantly related to the following coping skills. Results show that Feeling Wise with clients among therapists in this study was significantly positively related to all items related to coping except only one significant negative correlation of perceived clinical wisdom: Consult about the case with a more experienced therapist. In other words, therapists who reported feeling Wise with their clients were less likely to report consulting with a more experienced therapist when facing difficulties in practice.

Factor analysis of the 22 scales (11 bidirectional) identified the following six dimensions in past studies (Orlinsky & Rønnestad, 2005):

1. Exercise reflective control
2. Seek consultation
3. Problem solving with client
4. Reframing the helping contract
5. Seeking alternate satisfactions
6. Avoiding therapeutic engagement

Table 11. Correlation Between Self-Perceived Clinical Wisdom and Coping Skills

Coping Skills	**Correlations (Pearson's *r*)**
Try to see the problem from a different perspective.	.128**
Share your experience of the difficulty with your client.	.078**
Seek some form of alternative satisfaction away from therapy.	.058**
Make changes in your therapeutic contract with a client.	036*
Just give yourself permission to experience difficult or disturbing feelings	.055**
See whether you and your client can together deal with the difficulty	.080**
Consult about the case with a more experienced therapist.	-.055**
Sign up for a conference or workshop that might bear on the problem	.071**
Invite collaboration from a client's friends or relatives.	.032*
Modify your therapeutic stance or approach with a client.	.076**

**Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Later, a single scale was constructed of the positive dimensions called *constructive coping* ($\alpha = .73$) and consisted of the following items: problem-solving with clients, seeking consultation, and positive aspects of exercising reflective control. This study used the 6-point scale consisting of 11 items. The data from the therapists in the sample was also tested on this higher-order scale to reconfirm the way therapists managed difficulties. Table 12 presents the results.

The group of therapists who felt Very Much Wise with their clients seemed to use the reflective aspects of coping in significantly higher proportion than the other group of Wise therapists. This involved trying to see the problem from different perspectives, spending time reviewing the problem privately, giving themselves permission to experience the upset feelings associated with the problem, and exploring if the client and the therapist could deal with the

difficulty in the therapeutic engagement together. There was no difference in the way the therapists in the sample (who differed on self-perception of clinical wisdom) used the coping mechanism of revising and reframing when facing difficulties in practice. The therapists who perceived they were Very Much Wise with their clients however, differed significantly from the therapists who felt Somewhat Wise in their higher use of constructive coping (i.e., positive coping rather than negative coping). This represents a significant difference from the therapists who reported feeling Somewhat Wise or Not Wise at All with their clients.

Table 12. Relationship Between Self-Perceived Clinical Wisdom and Dimensions of Coping Skills

Dimension of Coping	***F***	***P***	**Post Hoc** [a]
Seek Consultation	.38 (3, 4021)	.769	N/S
Revise/ Reframe	3.42(3, 4016)	.017	N/S
Avoid therapeutic engagement	4.32 (3, 4018)	.005	**2** > 0
Reflect	13.85 (3, 4018)	<.001	**3** > 1
Constructive coping	4.03(3, 3997)	.007	**3** > 1

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

N/S= Non Significant Difference

Interpersonal-Affective Aspects of Practice

This section studies the interpersonal affective or the social-emotional aspects of the therapist as these aspects emerge in the therapy space in relation to therapists' perceptions of Being Wise with clients. Aspects of the therapists include therapists reporting: (a) the way they handle the frames and boundaries of the therapeutic engagement, (b) their relational manner or style of relating to the clients, (c) feeling in-session regarding the clients, and (d) inter-session experiences about patients (i.e., therapists' thoughts and affects regarding clients between-sessions).

Frame and Boundary Management (Norms and Limits of the Therapist Role)

The way the therapists managed the therapeutic frame and its relation to perceived clinical wisdom was measured on the DPCCQ by the question, *With clients in your current practice, how often do you . . .?* This was followed by a 10-item scale related to the ethics of clinical practice. The responses on the 10 items were measured on a 6-point scale of 0-5 where 0 = Never and 5 = Very Often.

Table 13 shows the results of the initial correlations of the 10 items in the scale of frames with the dependent variable Feeling Wise with clients. Four items in the scale were positively significantly correlated with therapists' self-perceived clinical wisdom; namely, flexibility in scheduling additional sessions if needed, initiating or receiving phone calls, initiating or accepting nonsexual touch, and having social or professional relationships outside of therapy. To further study how the four groups of therapists differed on these items, the differences in the mean scores of the groups of therapists were explored using ANOVA and post hoc Scheffe test.

Table 13. Relationship Between Self-Perceived Clinical Wisdom and Therapeutic Frame Management

Frames	***r (with wise with clients)***	***F***	***P***	**Post Hoc** [a]
Schedule periodic additional sessions.	.081**	11.03 (3, 3930)	<.001	**3**>1
Initiate or receive telephone calls.	.067**	6.13 (3, 3928)	<.001	**3**>0
Have social or professional relationships outside of therapy.	.072**	8.97 (3, 3928)	<.001	**3**>1
Initiate or accept nonsexual contact.	.117**	19.50 (3, 3938)	<.001	**3**>0, 1
Agree to meet in other locations.	.021	.98(3, 3928)	.401	N/S
Allow sessions to run longer than scheduled.	.001	1.04 (3, 3927)	.373	N/S
Intercede on patients' behalf with others.	.022	1.75 (3, 3916)	.155	N/S
Allow interruptions during sessions.	-.02	2.05 (3, 4041)	.105	N/S
Engage in extraneous activities during sessions.	-.01	.92 (3, 201)	.432	N/S

** Correlation is significant at the 0.01 level (2-tailed)

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

N/S= Non Significant Difference

In addition, Table 13 shows that therapists who feel Very Much Wise with their clients are also significantly higher on the following four items: flexibility in scheduling additional sessions if needed, initiating or receiving phone calls, initiating or accepting nonsexual touch, and a significant positive correlation with having social or professional relationships outside of therapy.

Factor analysis of the items in the scale revealed two higher-order dimensions, which have been called *frame flexibility* ($\alpha = 0.60$) and *boundary laxity* ($\alpha = 0.68$) in past studies (Orlinsky & Rønnestad, 2005). Schroder and Orlinsky (2011) saw these factors separating

flexibility from major alterations in the therapeutic frame. The factor of frame flexibility related to the arrangements of the session while personal boundary laxity related to attempts to change the tone of the session from professional to personal. ANOVA revealed that the therapists who perceived they were Very Much Wise with their clients differed significantly from the other Less Wise therapists on the dimension of frame flexibility [F = 10.03 (3, 3926), p <.001]. The Very Wise therapists showed significantly more frame flexibility (M = 2.19) than the Somewhat Wise group of therapists (M =1.9) when multiple comparisons were made using the Scheffe's test. On the dimension of boundary laxity, a significant difference existed between the groups of therapists differing in perceived wisdom with clients [F = 3.03 (3, 3921), p =.028] at the .05 level of significance.

Relational Manner (Style of Relating Self-in-Therapist's Role to Clients)

Relational manner refers to the elements of the therapeutic bond or the connection between the therapist and the client, which is more than the professional therapist-client contract. It is about the person of the therapist meeting the person of the client and how they interact together (Bordin, 1979; Orlinsky & Howard, 1987; Orlinsky & Rønnestad, 2005). The scale in the DPCCQ that measures relational manner has 24 items based on Leary's (1957) circumplex model. The responses to these items followed the question, *How would you describe yourself as a therapist—your actual style or manner with clients*. The responses on the 24 items measuring relational manner ranged from 0-3 with 0 = Not at All and 3 = Very Much. Factor analysis of items revealed the following four dimensions of the therapeutic bond or relational manner in previous studies with the data collected using the DPCCQ by the CRN (Orlinsky & Rønnestad, 2005): *affirming* (consisting of warm, involved, friendly, tolerant, nurturing, and accepting

(α=.73); *directive* (consisting of demanding, directive, determined, critical, and authoritative (α=.65); *reserved* (consisting of reserved, guarded, detached, and cold (α=.62); and *effective* (consisting of skillful, effective, and organized (α=.67). The four groups of clinically wise therapists differed from each other in their relational manner, as shown in Table 14.

Table 14. Relationship Between Self-Perceived Clinical Wisdom and Relational Manner

Relational Manner	***F***	***P***	**Post Hoc** [a]
Affirming	249.50 (3, 4119)	<.001	**3**>2>1>0
Directive	21.84 (3, 4115)	<.001	**3**, 2> 1, 0
Reserved	7.71 (3, 4106)	<.001	**2**, 1, 3 >0
Effective	364. 57 (3, 4113)	<.001	**3**>2>1>0

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

As shown in Table 14, the therapists who perceived they were Very Wise with their clients also perceived their manner of relating to their clients was affirming, effective, and directive—which is significantly different and higher than the other therapists in the sample.

Therapists' Feelings in the Therapy Session (Therapist's Personal Affects Regarding Clients *Within-Session*)

The feelings that the therapists' experienced during the work of therapy are referred to as *in-session feelings.* A set of 20 adjectives representing aspects of flow, anxiety, and boredom, based on Csikszentmihalyi's (1990) model of states of experience, was used in the DPCCQ to examine therapists' in-session feelings. Initial correlations revealed significant positive correlations between Feeling Wise with therapists and feeling engrossed, inspired, stimulated, available, calm, creative, focused, and relaxed in-sessions. Significant negative correlations were

seen with feeling anxious, challenged, inattentive, overwhelmed, pressured, tense, and unsure. There were no significant correlations with feeling bored, absent, or distracted in sessions. ANOVA of these items related to in-session feelings and the levels of self-perceived clinical wisdom in therapists revealed significant differences between therapists on in-session feelings of anxiety, feeling engrossed, inattentive, inspired, pressured, stimulated, available, calm, creative, focused, tense, relaxed, and unsure.

Factor analysis of these 20 scale items yielded three dimensions in past published studies using the DPCCQ (Orlinsky & Rønnestad, 2005). The three dimensions correspond to states of anxiety, flow, and boredom. Exploration of how the four different levels of self-perceived, clinically-wise therapists perceived they were in-session was carried out by using ANOVA and Scheffe's post hoc test. Table 15 displays the results.

Table 15. Relationship Between Therapist Self-Perceived Clinical Wisdom and In-Session Feelings

In-Session Feelings	***F***	***P***	**Post Hoc** [a]
Flow (inspired and stimulated; α = .63)	71.07 (3, 4044)	<.001	**3** > 2 >1,0
Bored (bored, drowsy, inattentive; α = .69)	.98 (3, 4062)	.402	N/S
Anxiety (pressured, overwhelmed, unsure, anxious; α = .66)	26.92 (3, 4042)	<.001	**0** > 2 >3
Available	149.09(3, 4032)	<.001	**3** > 2 >1, 0

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

N/S= Non Significant Difference

Therapists who perceived they were Very Wise with clients reported feeling the least amount of anxiety in-sessions with clients. In addition, they felt available, inspired, and more stimulated, as compared to the Lesser Wise therapists.

Therapists' Inter-Session Experiences about Patients (Therapist's Thoughts and Affects Regarding Clients *Between-Sessions*)

Therapist inter-session feelings refer to the feelings that a therapist has about clients between two sessions. These were measured on the DPCCQ by a scale consisting of five items, which are theoretically drawn from the psychoanalytic concept of countertransference or a form of homework that therapists engage in before meeting a client the next time (Schröder et al., 2009).

Frequency of inter-session experiences were examined to see how many therapists in the sample endorse each of these items, which were measured on a 6-point scale ranging from 0-5 where 0 = Never and 5 = Very Often, following the question, *In the last few days outside of sessions, how often have you found yourself . . .?* This question was then followed by the five items related to the inter-session experiences of the therapists regarding their clients. In this study sample, 50% (n = 1317) of the therapists reported thinking Moderately Often to Very Often about how best to help resolve a client's problems and approximately 45% (n = 1180) remembered feelings expressed by the client in the inter-session period Moderately Often to Very Often. A similar percentage of therapists reported reflecting Moderately to Very Much on their own feelings regarding a client in between sessions 43% (n = 1127) and approximately 71% (n =1979) of the therapists reported that they Never, Rarely, or Occasionally imagined a conversation with their clients in the inter-session period. Lastly, only 19% of the therapists said

they experienced something similar to what their clients have Moderately Often to Very Often while 34% reported that they Never Felt or Rarely experienced something similar to what their clients experienced.

These results were further examined using ANOVA and post hoc Scheffe test to see how the therapists (with differing levels of self-reported clinical wisdom) performed on these items of inter-session experiences.

Table 16. Relationship Between Therapist Self-Perceived Clinical Wisdom and Inter-Session Feelings

Inter-Session Feelings	***F***	***P***	**Post Hoc** [a]
Thinking how best to help resolve a client's problems.	2.80 (3, 2615)	.039	**0**>2, 3 > 1
Remembering feelings expressed by a client.	2.52 (3, 2614)	.056	No difference
Reflecting on your own feelings toward a client.	2.49 (3, 2611)	.059	0 >2, 3 > 1
Imagining a conversation with a client of yours.	2.69 (3, 2609)	.045	No difference
Experiencing something similar to what a client has experienced.	6.43 (3, 2612)	<.001	**0** >2, 3 > 1

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

The results displayed in Table 16 showed that the therapists who felt More or Less Wise with clients (i.e., Not at All Wise with their clients) were significantly different from the rest of the therapists in that they were thinking about how best to resolve a client's problem between sessions and experienced something similar to what their client had experienced between sessions.

Summary

The results of the study practice correlates of therapists who felt More or Less Wise with clients were presented. Practice correlates in relation to the self-perceived clinical wisdom of therapists was analyzed under two broad sections of technical-instrumental aspects and interpersonal-affective aspects. A summary of the results follows.

Treatment goals: The Top Five endorsed goals of Wise and Not Wise therapists in the sample are the same. The goal that was most commonly endorsed was, Helping clients have a strong sense of self-worth and identity, followed by Helping clients understand their feelings, motives, and behavior. The third most commonly endorsed goal was, Helping clients recognize and change how they contribute to their own problems. This was followed by, Helping clients improve the quality of their relationships. The fifth goal that was endorsed alike by Wise and Not Wise therapists was, Helping clients to experience a decrease in their symptoms. The least commonly endorsed goals by therapists were, Helping clients resolve cultural conflicts, Helping clients evaluate themselves realistically, and Developing better ability to meet familial and social responsibilities. These least commonly endorsed goals were also common across the different levels of wise therapists in the study.

Clinical skills: Therapists who felt Very Much Wise with their clients also felt they possessed significantly higher levels of basic, relational, and advanced level skills than the therapists who felt Somewhat Wise, Much Wise, or Not at All Wise with clients.

Difficulties in practice: Therapists who felt Very Much Wise with clients consistently perceived hey have significantly lower amounts of difficulty in practice, as compared to the other groups of therapists.

Coping strategies: The group of therapists who felt Very Much Wise with their clients seemed to use significantly higher levels of reflective and constructive aspects of coping with difficulties in practice.

Frame and boundary: Therapists who perceived they were Very Much Wise with their clients held the therapeutic frame in a significantly more flexible manner, as compared to the other therapists.

Relational manner: The therapists who perceived they were Very Wise with their clients also perceived their manner of relating to their clients was affirming, effective, and directive, which is significantly different and higher than the other therapists in the sample.

Therapists' feelings in the therapy session: Therapists who perceived they were Very Wise with clients reported feeling the least amount of anxiety in-sessions with clients. In addition, they felt significantly more available, inspired, and stimulated, as compared to the Lesser Wise therapists.

Therapists' inter-session experiences about patients: The therapists who felt Least Wise with clients (i.e., Not at All Wise with their clients) were significantly different from the rest of the therapists in that they were thinking about how best to resolve a client's problem between sessions and experiencing something similar to what their client had between sessions.

In Chapter Five, the personal and professional correlates of the therapists who felt Wise with clients will be examined.

CHAPTER FIVE

RESULTS—PRACTITIONER CORRELATES

This study explored the practice and practitioner characteristics of therapists who perceived they were wise with clients. Chapter Four of this study examined the practice characteristics of wise therapists. This chapter describes the study results related to practitioner correlates. As per the research questions, the distinguishing personal and professional characteristics of the therapists who perceive that they are wise with their clients are delineated. For ease of organization of the study findings, practitioner correlates were divided along the following two dimensions: (a) professional characteristics and (b) personal characteristics. Professional characteristics refer to the aspects of therapist development that are related facets of their professional identity, professional training, and professional growth. Personal characteristics include therapist's age, sex, nationality, marital status, quality of life, and wisdom in close personal relationships.

I. Professional characteristics
    a. Career level or years in practice
    b. Experienced career development to date
    c. Professional identity
    d. Theoretical orientation
    e. Training and supervision
    f. Personal therapy (utilization and experienced benefit)

g. Experienced current development

II. Personal characteristics

a. Wisdom in close personal relationships

b. Therapist age and sex

c. Therapist marital and parental status

d. Therapist quality of life (positive and negative) and emotional well-being

e. Nationality

Professional Characteristics

Career Level or Years in Practice

The DPCCQ examines this variable by asking therapists how long they have been in practice—including practice during the training period. In the researcher's sample of therapists, the average years of practice was 14. 19 (*SD* = 9.8). There was a significant positive correlation between years in-practice and therapists' reports of feeling Wise with clients (*r* =.164**, *p* = <.01). In previous studies published on DPCCQ data, therapists (based on their years of practice) were thoughtfully divided into groups to simulate cohorts at different career levels so the data could be analyzed more meaningfully (Orlinsky & Rønnestad, 2005). This study followed the same approach, dividing the data into six meaningful cohorts; namely, novice (>0 to <1.5 years), apprentice (1.5 to <3.5 years), graduate (3.5 to <7 years), established (7 to <15 years), seasoned (15 to <25 years), and senior (25 to <55 years). An initial Chi-square test was done to determine the relationship between years in practice and feeling wise with clients. As per the results described in Table 17, on average, most therapists in the study were feeling Much Wise (52%) or Very Much Wise (26%) with 22% reporting they felt Somewhat Wise or Not Wise at All.

Table 17. Self-Perceived Clinical Wisdom and its Relation to Career Level of Therapists

Years in Practice	**Level of Self-Perceived Clinical Wisdom**				
	Not at All Wise (N)	Somewhat Wise (N)	Much Wise (N)	Very Much Wise (N)	Total
>0 to <1.5 years	5	44	60	12	121 (3%)
1.5 to <3.5 years	15	68	158	50	291 (7.1%)
3.5 to <7 years	26	166	356	128	676 (16.6%)
7 to <15 years	30	267	686	336	1319 (32.4%)
15 to < 25 years	26	154	539	298	1017 (25%)
25 to < 55 years	22	78	323	225	648 (15.9%)
Total	124 (3%)	777 (19.1%)	2122 (52.1%)	1049 (25.8%)	4072 (100%)

To further examine which of the groups differ from each other on the variable of feeling Wise with clients in relation to years in practice, the difference among the means was analyzed using ANOVA. The results showed a significant difference among levels of self-perceived wisdom in therapist cohorts based on years of practice [F (5, 4066) = 21.24, p < .001]. The groups that differed significantly were analyzed post hoc using the Scheffe's test. The results showed that the following therapists groups, based on years of practice, significantly differed from each other (α = .05) on how Wise they felt with their clients. The group of therapists with 25-55 years of practice experience had the highest mean (M = 2.16) on self-perceived clinical wisdom, followed by therapists with 15 to <25 years (M =2.09), followed by 3.5 to <7 (M =1.87), and lastly, the therapists who had the least amount of practice years had the lowest means on feeling Wise with clients >0 to <1.5 years (M =1.65). The results indicate that the therapists with the most years of practice years perceive that they are significantly Wiser with their clients

than the ones with the least years of practice who feel the Least Wise with their clients. This difference is statistically significant.

Experienced Career Development to Date

Experienced career development refers to the therapists' overall experience of development as a professional therapist from when they entered the profession (saw their first real client) to the present day. Five questions in the DPCCQ asked therapists directly about how much they changed overall since beginning their practice. These items were rated on a scale of 0-5 where 0 = Not at All and 5 = Greatly. To compare how the groups of self-perceived wise therapists review their career development, ANOVA was used to compare the means and subsequently, Scheffe's test was used to compare which of the groups were significantly different from each other. Table 18 presents these results.

Table 18. Self-Perceived Clinical Wisdom and Therapists' Experienced Career Development

Experienced career development to date	***F***	***p***	**Post hoc** [a]
Overall change as a therapist	8.35 (3, 4083)	<.001	**3** >1, 0
Progress or improvement	17.38 (3, 4077)	<.001	**3** > 0, 1
Decline or impairment	4.26 (3, 4081)	.005	**0** > 2, 1, 3
Overcoming past limitations as therapist	57.71 (3, 4060)	<.001	**3** >2 >1, 0
Realized potential for development as therapist	81.9 (3, 3202)	<.001	**3** >2 > 0, 1

[a] = Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise, 0 = Not at All Wise

Table 18 shows that therapists who perceived they were Very Much Wise with their clients, reported feeling a significantly higher sense of professional growth and positive development when they reflected on their professional development, as compared to the therapists who felt Much Wise, Somewhat Wise, or Not Wise at All with their clients.

To explore the question of therapists who experience their career development as a decline or impairment, cross-tabs were used to examine how many therapists feel a sense of decline or impairment in their professional careers (see Table 19).

Table 19. Self-Perceived Clinical Wisdom and Therapists' Experienced Career Decline

	Levels of experienced decline or impairment in career development						
Levels of self-perceived wisdom	Not at all	Little	Somewhat	Moderately	Much	Very much	Total
Not at All	90	18	11	5	1	3	128
Somewhat	565	162	32	15	6	1	781
Much Wise	1531	442	86	44	19	9	2131
Very Much	803	173	41	16	9	3	1045
Total	2989 (73.2%)	795 (19.5%)	170 (4.2%)	80 (2.0%)	35 (0.9%)	16 (0.4%)	4085 (100%)

Table 19 shows that most of the therapists in the sample (93%) are *not* experiencing their career development as a decline or impairment. A relatively small percentage (about 1%) of the therapists (n = 51) reflect on their career and experience as Much or Very Much in decline. Of these therapists, 12 perceive that they are Wise with clients and four feel Somewhat Wise and Not at All Wise with their clients.

Professional Identity

To explore the question regarding the professional identity of the therapists and its relation to therapists feeling Wise with their clients, an initial examination of the sample was performed. . The analysis revealed that 39% of the sample identified as psychologists, 36% as counselors, 8% as analysts/therapists, close to 5% as social workers, close to 5% as therapists

from nursing, 4% as psychiatric or medically trained therapists, and 3% responded to the choice of professional identity as Other .

A Chi-square test of independence was implemented to determine the relation between the professional identity of therapists and therapists' self-perception of being Wise with their clients. The relation between these variables was significant with χ^2 (18, N = 4126) = 40.84, p =.002 showing that there is a relationship between feeling differentially Wise with clients and the core profession in which the therapists identify. Comparing the means of the six professions (and the Other professional category) on how they have responded to the question on feeling wise with clients using ANOVA, a significant difference was seen among the professional groups F (6, 4119) = 2.344, p = .029. Scheffe's post hoc analysis showed that social work had the highest mean (M=2.13) followed (in descending order) by psychology, counseling, analyst/therapist, nursing, and psychiatry (M=1.91). This means that in the sample of psychotherapists, social workers perceived they were Much Wiser with clients than other professional groups and psychiatrists perceived they were Least Wise with their clients in comparison to other professional specializations.

Theoretical Orientation

To explore the question regarding the theoretical orientation of the therapists and its relation to therapists feeling Wise with their clients, an initial examination of the descriptive data was performed. Since all therapists could mark themselves as having more than one theoretical orientation, the concept of saliency was used for descriptive analysis of how strongly therapists endorsed a particular theoretical orientation. A theoretical orientation was considered salient if a therapist marked him or herself as a 4 or 5 on a 6-point scale (ranging from 0 = Not at All to 5 =

Very Greatly) on a question that asked, *How much influence did a particular theoretical orientation have on your current practice?* For descriptive analysis, as per previous studies (Orlinsky & Rønnestad, 2005), therapists who reported their practice as having been influenced by one orientation were called monofocal; the therapists influenced saliently (marked a 4 or 5) by two theoretical schools were called bifocal; and the therapists influenced by three or more orientations were referred to as broad-spectrum.

In the sample, 6% of the therapists reported no salient orientation (they could have been influenced to a lesser degree by theoretical schools), 47% reported having one salient orientation (may have had more than one non-salient influence), 28% reported having two salient theoretical orientations (bifocal), and 18% reported having a broad-spectrum theoretical influence on their current practice. The most commonly endorsed (rated salient) theoretical orientation of the sample was analytic-psychodynamic (17%) followed by humanistic (12%), then cognitive-behaviorist (10%). The most commonly endorsed combination of two therapies was humanistic, combined with some other orientation besides the ones mentioned (5%), analytic-psychodynamic + humanistic (4%), and cognitive-behavior + humanistic (4%). Table 20 shows the salient orientations of therapists and their differential responses to feeling Wise with clients.

Table 20. Self-Perceived Clinical Wisdom and Therapists' Salient Theoretical Orientation

	Salient Theoretical Orientation (4 + 5) [a]				
	Analytic-Psychodynamic (*N* = 4117)	Cognitive (*N* = 4112)	Behavioral (*N* = 4119)	Humanistic (*N* = 4118)	Systemic (*N* = 4117)
Not at All Wise	53(1.3%)	37 (0.9%)	26(0.6%)	30 (0.7%)	30(0.8%)
Somewhat Wise	311	227	153	242	156
Much Wise	764	690	477	763	508
Very Much Wise	411(10%)	389 (9.4%)	243(5.9%)	462 (9.2%)	303(7.3%)
Total	1539	1343	899	1497	997

[a] An orientation was considered salient if therapists marked themselves as a 4 (Greatly) or 5 (Very Greatly) and influenced by that theoretical school on a 6-point scale where 0 = Not at All and 5 = Very Greatly (multiple ratings were allowed).

Table 21. Chi-Square Test for Theoretical Orientation X Levels of Self-Perceived Clinical Wisdom

Orientation	**Chi-Square Values**
Analytic psychodynamic	χ^2 (15, N = 4117) = 30.7, p =.010*
Cognitive	χ^2 (15, N = 4112) = 34.55, p =.003**
Behavioral	χ^2 (15, N = 4119) = 16.88, p =.326
Cognitive-behavioral (addition of cognitive and behavioral)	χ^2 (30, N = 4112) = 46.75, p =.026*
Humanistic	χ^2 (15, N = 4118) = 91.23, p < .001**
Systemic	χ^2 (15, N = 4117) = 34.47, p =.003**

**Chi-square value is significant at the 0.01 level (2-tailed)
*Chi-square value is significant at the 0.05 level (2-tailed)

Table 21 shows that a significant difference exists among the therapists in the sample on how Wise they feel if their theoretical orientation is analytic psychodynamic, cognitive, cognitive-behavioral, humanistic, or systemic. The behavioral therapists in the sample did not differ from each other on how Wise they reported feeling with their clients.

On another item on the DPCCQ, therapists were asked to rate (on a scale of 0-5) how eclectic or integrative their theoretical orientation is currently. An ANOVA was performed to determine if any relation existed between how eclectic or integrative a therapist was and how Wise they felt with their clients. The results clearly showed that therapists who considered themselves as more eclectic or integrative also perceived themselves as Wiser with their clients [F (5, 3844) = 26.38, $p < .001$]. Post hoc analysis with Scheffe's test showed that the *very much integrative* therapists felt Very Much Wise (M = 2.18). This difference was significantly greater than the therapists who described themselves as *much integrative* (M = 1.97). The therapists who described themselves as *not at all integrative* reported feeling Wise with their clients the least (M = 1.75).

Training and Supervision[1]

DPCCQ refers to training as years of training a therapist has received. The therapists' sample had an average of 6.2 years of training (SD = 5.21). Didactic training was significantly positively correlated with self-perceived clinical wisdom [r (1600) = .104**, p = <.001]. Therapists with more years of didactic training reported that they felt significantly wiser with their clients as compared to therapists with lesser years of training.

To answer the question of if years of supervision make a difference in how Wise therapists perceived they were with their clients, an initial look at the sample showed that the therapists in our sample had an average of 8.7 years of supervision (SD = 6.77). Of these therapists, 74% were still seeking professional supervision while 26% were not. Having had

[1]However, when we control for years of practice of a therapist in the correlation, this significant positive effect is no longer seen. In fact, we see a nonsignificant negative effect r = -20, p = .05. The relationship between supervision and feeling wise with clients was confounded by the years of practice as a therapist. The more years of practice the therapist had, the less supervision they sought.

supervision was significantly positively correlated with self-perceived clinical wisdom [*r* (1600) = .063**, p = <.001].

To explore the relationship of supervision with feeling Wise, another question in the DPCCQ asked therapists if they had supervised other therapists. On average, therapists in the sample stated that they had supervised two other therapists (N = 3694). While 30% of the sample had not supervised any other therapists, 16% of the sample had supervised 1-3 therapists, 20% had supervised 4-9 therapists, 13% had supervised 10-15 therapists, 8% had supervised 16-24 therapists, and 14% had supervised 25 or more therapists. There was a significant positive correlation between the number of other therapists supervised and feeling Wise with clients (*r* =.132**, *p* = <.001). ANOVA showed significant differences amongst therapist self-perception of being Wise with clients based on the number of therapists supervised by them *F* (5, 3688) = 17.34, *p* < .001. Post hoc Scheffe test showed that the therapists who had not supervised other therapists felt Least Wise with their clients (*M* = 1.86) and the ones that had supervised 25 or more therapists in their career felt Significantly Wiser with their clients (*M* = 2.18).

Personal Therapy (Utilization and Experienced Benefit)

Exploring therapist's self-perception of clinical wisdom and its relation to personal therapy was implemented in four ways:

1. Descriptive analysis to explore how many therapists have been in personal therapy.
2. Utilization of personal therapy and its relation to self-perceived clinical wisdom by using Chi-Square test of independence of means.
3. Positive and negative impact of personal therapy on development as a professional therapist and its relation to self-perceived clinical wisdom using ANOVA.

4. Perceived benefit of personal therapy and its relation to self-perceived clinical wisdom using ANOVA.

The results of this initial exploration showed that 25% of the sample were currently in personal therapy (N = 1035) while 88% of the sample had received personal therapy sometime in their lives (N = 3581). Of the 202 therapists who answered the question relating to the importance of personal therapy, 73% felt that personal therapy is important and should be required for all therapists (N = 147); another 20% felt that personal therapy is desirable for most practitioners (N = 147).

To further explore the research question related to the relationship of feeling Wise with clients and the utilization of personal therapy, the Chi-square test of independence of means was conducted. Table 22 presents the results of the Chi-square test. The Chi-square test shows that a significant difference existed among therapists who had been in personal therapy and therapists who had not been in personal therapy on how Wise they felt with their clients.

Table 22. Utilization of Personal Therapy and its Relation to Self-Perceived Clinical Wisdom

		Wise with Clients				
Personal Therapy		Not at all	Somewhat	Much	Very Much	Total
Ever had personal therapy	No	17	106	286	97	506
	Yes	106	677	1851	947	3581
	Total	123 (3%)	783 (19%)	2137(52%)	1044 (25%)	4087

χ^2 (3, N = 4087) = 12.4, p =.006**
** Chi-Square value is significant at the 0.01 level of significance (two tailed)

To further understand personal therapy and its relation to therapists feeling Wise with clients, a further question in the DPCCQ asked therapists the impact (either positive or negative)

of undergoing personal therapy on their own life and how much of their own development as a therapist was influenced by exploring their own issues in personal therapy. These three subquestions were marked on a 6-point scale with 0 = Not at All and 5 = Very Greatly influenced. ANOVA showed a significant difference existed among the therapists on how Wise they felt with their clients based on how much positive impact they felt personal therapy had on their lives [F (3, 3287) = 27.66, $p < .001$]. Post hoc Scheffe's analysis showed that the group of therapists who had reported the most impact of personal therapy also reported feeling significantly Wiser with their clients ($M = 4.19$), as compared to the other groups at $\alpha = .01$ level.

ANOVA was carried out to explore the relationship of the negative impact of personal therapy and self-perceived clinical wisdom with clients. It showed a significant difference among the therapists on how Wise they felt with their clients, based on how much positive impact they felt personal therapy had on their lives [F (3, 3233) = 4.83, $p < .001$]. Post hoc Scheffe's analysis showed that the group of therapists who reported experiencing the greatest negative impact of personal therapy felt the Wisest with clients at the 0.05 significant level, but this difference was not borne out at $\alpha = .01$ level.

To explore the professional developmental influence of personal therapy on self-perceived clinical wisdom with clients, ANOVA was implemented, which showed a nonsignificant trend or no difference between the means, F (3, 201) = .787, $p = .502$. It is important to note that this question was added later to the questionnaire and hence, was answered by only 201 therapists.

The last question in the DPPCQ explored the relationship of personal therapy with self-perceived clinical wisdom and asked therapists to rate, on a 3-point scale, how much they

benefitted from receiving personal therapy. Results looking at the descriptive analysis of the therapists who answered this question showed that 38% of therapists Benefited Greatly, 32% had Slightly Less Benefit, 18% had No Benefit at All, and 12% had Not Received Personal Therapy. ANOVA shows that the difference in these four groups is significant at $\alpha = .05$ level [F (3, 4083) = 3.45, p = .016]. Post hoc Scheffe's analysis showed that the group of therapists who had reported the Greatest Benefit of personal therapy also reported feeling wiser with their clients (M = 2.03); this was significantly greater than the group that had personal therapy, but had No Great Benefit (M = 2.02). Both of these groups felt significantly wiser at $\alpha = .05$ than the group of therapists that had never been in therapy (M =1.92).

Experienced Current Development

Therapists' experiences of their own development in this sample were explored in relationship to the variable of therapist's feeling Wise with clients. Twelve items in the DPCCQ measured the therapists' experiences of change (development) as positive growth and impairment on a 6-point scale.

Table 23 shows how the response of the therapists to the 12 questions relate to therapists' experiences of their own current professional development. As Table 23 details, a majority of the therapists (69%) experience their professional development as progress while 1% experience it as a decline or impairment. A large part of the sample reported feeling that they are becoming more skillful in practicing therapy (70%). A similar percentage reported a sense of deepening their understanding of psychotherapy (72%). In addition, a large percentage of the sample reported feeling a sense of growing enthusiasm about doing therapy (56%) and a majority of the sample responded that further development as a therapist is very important (85%).

Table 23. Self-Perceived Clinical Wisdom and Therapists' Experiences of Current Professional Development

				Levels of Current Professional Development (%)					
Items	N	M	SD	**Not at All**	**Little**	**Somewhat**	**Moderately**	**Much**	**Very Much**
Changing as a therapist	4049	3.23	1.07	.6	6.9	14.8	34.8	32.7	10.2
Change feels like progress	4041	3.79	1.05	1.2	2.5	6.9	20.2	43.5	25.7
Change feels like impairment	4032	.46	.84	69.7	19.8	6.2	3.3	.8	.2
Overcoming past limitations	4041	3.41	1.15	2.1	4.8	12.0	27.6	38.3	15.2
Becoming more skillful	4040	3.81	1.00	.8	2.2	6.6	20.5	45.4	24.5
Deepening your understanding	4044	3.87	1.01	.8	2.3	6.2	18.4	44.3	28.0
Growing sense of enthusiasm	4041	3.50	1.24	2.9	4.8	10.6	25.3	33.6	22.8
Becoming disillusioned	4038	.81	1.15	56.0	22.6	9.9	7.9	2.7	.9
Losing capacity to respond empathically	4044	.58	1.04	66.8	20.0	5.8	4.0	2.4	.9
Performance becoming routine	4046	.81	1.06	51.0	29.5	9.9	6.9	2.3	.4
Capable to guide other therapists	4040	3.34	1.25	3.0	7.3	11.4	25.3	37.0	16.0
Importance of further development as a therapist	4062	4.33	.98	1.0	1.6	2.8	9.8	27.4	57.4

Table 23 also highlights that a very small percentage of the sample of therapists (3%) are losing the capacity to respond with very much empathy to clients and are becoming very disillusioned (4%), feeling that their performance as a therapist is becoming very routine (3%).

Past studies have factor-analyzed the top 10 items and two stable dimensions emerged from the factor analysis (Orlinsky & Rønnestad, 2005). The first of these dimensions consisted of all the positive items and was named, Currently Experienced Growth. The second dimension consisting of the four negative questions was named, Currently Experienced Depletion and suggested erosion of skills and responsiveness. However, an interesting aspect regarded the low negative correlation between the two dimensions, indicating that therapists can experience either or both in varying degrees. This study analyzed therapists along the two dimensions of Currently Experienced Growth and Currently Experienced Depletion (see Table 24) and shows that a large part of the therapists experience their development as growth (68%) while a very small part experience their professional development as a decline or impairment (1%).

Table 24. Dimensions of Career Development and Its Relation to Self-Perceived Clinical Wisdom in Therapists

Dimensions	**N**	**M**	**SD**	% Not at All	% Little	% Somewhat	% Moderately	% Much	% Very Much
Currently Experienced Growth	4033	3.47	.90	.2	1.7	7.3	22.8	46.6	21.4
Currently Experienced Depletion	4010	.97	.89	33.3	43.0	17.2	5.7	.7	.1

Figure 2 pictorially represents the percentage of therapists who are experiencing their current professional development as growth.

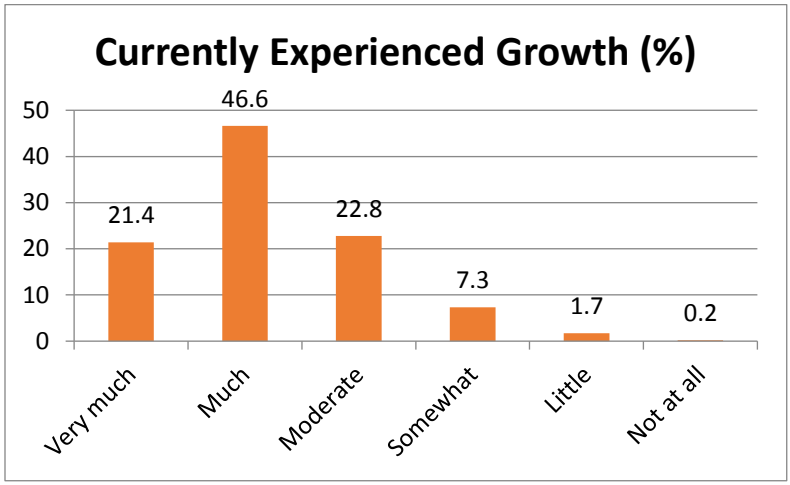

Figure 2. Therapists' Experiences of Professional Development as Growth.

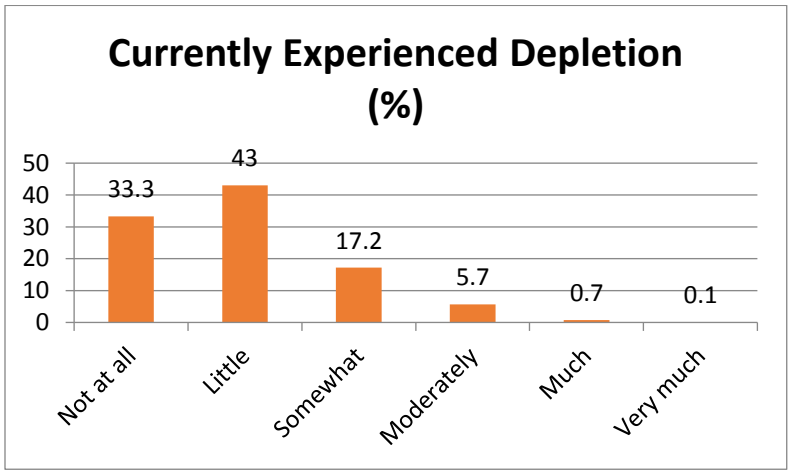

Figure 3. Therapists' Experiences of Professional Development as Depletion.

To explore the relationship of currently experienced development with therapists' perceptions of being Wise with clients, ANOVA was implemented using the two dimensions of growth and depletion. ANOVA was executed to study the experience of current development as *growth* for the therapists in the sample, which showed a significant difference [F (3, 4029) = 21.73, $p < .001$] based on differences in perceived wisdom with clients. Post hoc Scheffe's test showed that the therapists who felt Very Wise with their clients had a significantly enhanced

perception of their development as growth (M = 3.66) and this was significantly higher and different at α = .05 level from the other groups who felt Not at All Wise, Somewhat Wise, or Much Wise with their clients. The therapists in the sample showed a significant difference in the experience of current development as depletion [F (3, 4006) = 2.94, p = .032] at α = .05 level; however, post hoc tests were not able to determine which groups differed significantly from each other.[2]

Personal Characteristics

This section explores the relationship between therapists' perceptions of being Wise with clients in relation to who they are personally (as persons and not as therapist).

Wisdom in Close Personal Relationships

A question in the DPCCQ examined whether therapists who report feeling Wise with their clients also felt Wise in their close personal relationships. This item was scored on a 4-point scale with 0 = Not at All and 3 = Very Much Wise. Initial examination of the item showed that of the 3,636 therapists who answered that question, 29% felt Very Much Wise in their close personal relationships, 54% felt Much Wise, 16% felt Somewhat Wise in their close personal relationships, and 2% felt Not Wise at All. Initial correlations also revealed that the two items (therapists' self-perceived clinical wisdom with clients and self-perceived wisdom in close personal relationships) were highly positively correlated [r (3636) = .653**, p = <.001]. To examine this item in relation to a therapist's self-perception of feeling Wise with clients, the Chi-square test of independence of means was implemented. Results are presented in Table 25.

[2] One of the reasons a difference does not exist between groups on post hoc tests, even when the F statistic on ANOVA is significant, could be due to a low power of test. This issue can be addressed by increasing the sample size or using alternate post hoc tests.

Table 25. Relationship Between Self-Perceived Clinical Wisdom and Wisdom in Close Personal Relationships

		Wise with Clients				
		Not at all	**Somewhat**	**Much**	**Very Much**	**Total**
Wise in close personal relationships	Not at All	28	30	6	0	64
	Somewhat	24	385	169	9	587
	Much	37	263	1441	207	1948
	Very Much	13	20	280	727	1037
Total		102	698	1896	940	3636

χ^2 (9, N = 3636) = 2766.54, $p < .001$**

Of the therapists sampled, 20% reported feeling Very Wise with clients and perceived they were Very Wise in close personal relationships too. One percent of therapists perceived themselves to be neither Wise with clients nor in their close personal relationships. The ANOVA showed that significant differences were evident in the means of the four groups of clinically wise therapists on the variable of Wise in close personal relationships [F (3, 3632) = 902.03, $p < .001$]. Post hoc Scheffe's test revealed that the therapists who were feeling Not Wise at All in their close personal relationships were also feeling the Least Wise with their clients (M = .66). This difference was significantly lower than the score of the Somewhat Wise therapists (M = 1.28), which was significantly lower from the Much Wise therapists (M = 1.93). The group of therapists who felt Very Much Wise in their close personal relationships also perceived they were Very Much Wise with their clients and had the highest mean on self-perceived clinical wisdom (M = 2.65), which was significantly higher from the other therapists.

Therapist Age and Sex

Wisdom in the general population has often been seen as a function of age, suggesting that older therapists might report feeling More Wise with clients. In this study sample, the mean age of the therapists was 50.5 years (N=4057, *SD* = 11.04) and the median age was 51.41 years. To use age in a meaningful manner, it was divided into five subgroups, which also loosely correspond to therapist professional development cohorts. Group 1 refers to the age as a *student, intern, or early* practitioner (21-35); Group 2 refers to *middle age* practitioners (<35-45); Group 3 refers to *senior age* practitioners (<45-60); Group 4 (<60-75) refers to the *mid old* practitioners; and Group 5 (>75 years) refers to the *long old* practitioners. ANOVA was implemented to see if there was a difference between the age-based groups of therapists and how Wise they felt with their clients. A significant difference among the groups was seen on the variable of self-perceived wisdom with clients F (4, 4052) = 23.55, $p < .001$. Post hoc Scheffe test showed that the younger the therapist, the Less Wise they perceived themselves to be with their clients—with the oldest therapists feeling Significantly Wisest with their clients (Group 5 (M = 2.41)>, Group 4 (M = 2.12)>, and Group 1 (M = 1.75).

To differentiate the effect of age from the effect of years of practice on the therapists' perceptions of being Wise with their clients, since both these variables are significantly correlated in our sample (r = .59**, p <.001), a linear regression test was used to see which of the two (age, practice duration) predicted self-perceived clinical wisdom in therapists. The regression indicated that the two predictors explained 3.5% of the variance [R^2 =.035, F (2, 3992) = 72.6, p<.001]. Through the test, it was found that age significantly predicted therapists feeling wise with clients (β = .107, p <.001) as did years of practice (β = .103, p<.001).

Sex has been a variable (with a complex relationship) with wisdom in the general population. To study how sex relates to therapists' self-perceived clinical wisdom, this study undertook an initial examination using the Chi square test. As is evident from Table 26, 70% of the sample are women while men constitute 30%.

Table 26. Age X Levels of Self-Perceived Clinical Wisdom in Therapists

		Wise with Clients				
		Not at All %	Somewhat %	Much %	Very Much %	Total %
Sex	Female	2	14.1	36.8	17.3	70.1
	Male	1	5	15.5	8.3	29.9
Total		3.1	19.1	52.3	25.5	100

χ^2 (3, N = 4100) = 8.88, p = .031(α = .01)

Further, as Table 26 shows, a difference was not seen among men and women regarding how Wise they perceived they were with their clients, according to the Chi-square test.To take the analysis a step further, four groups of age and sex were created to see if there was a particular gendered age group that felt Wiser than the rest of the therapists. The following groups were formed:

- Young adult women (20-29)
- Young adult men (20-29)
- Prime adult women (30-44)
- Prime adult men (30-44)
- Mature adult women (45-59)
- Mature adult men (45-59)
- Senior adult women (60-90)

- Senior adult men (60-90)

ANOVA was used to see if there was a difference in the means of these groups on the variable of interest (i.e., self-perceived clinical wisdom), followed by Scheffe's post hoc tests. ANOVA showed a significant difference among the groups F (7, 4027) = 14.78, $p < .001$. Post hoc tests showed that this difference was significant—with the young adult women group of therapists (20-29) having the lowest levels of self-perceived clinical wisdom (M = 1.70, N = 133) and the senior adult men (60-90) having the highest levels of self-perceived clinical wisdom (M = 2.24, N = 277).

Therapist Marital and Parental Status

Of the 4,046 therapists who answered the question on marital status, 14% were single, 12% were living with a partner, 60% were married or remarried, 11% were separated or divorced, 2% were widowed, and 1% chose the category of Other. ANOVA was used to determine if there was a significant difference in therapist's self-perceived clinical wisdom based on marital status. ANOVA showed a significant difference in therapist's self-perceived clinical wisdom based on marital status F (5, 4040) = 6.67, $p < .001$. Scheffe's post hoc analysis further revealed that the group of therapists living with a partner had the lowest mean on self-perceived clinical wisdom (M = 1.90) followed by single therapists (M = 1.92) and married or remarried therapists (M = 2.02). These three groups significantly differed from the Other marital status group (M = 2.35), which had the significantly highest mean at $\alpha = .05$ level.

The other variable of interest relates to the parental status of the therapist and if that status had any significant relation to therapist's self-perceived clinical wisdom. Initial analysis revealed that 74% of the therapists in the sample were parents and 24% were not. Pearson Chi-

square test was used to determine if there was a significant difference in means of the four groups of therapist's self-perceived clinical wisdom based on their parental status. A significant difference was seen [χ^2 (3, N = 4026) = 32.41, p <.001] indicating that there is a significant relationship between therapists' experiences of parenthood and their perceptions of being Wise with clients.

To further explore the relationship of marital status and parenthood together on self-perceived clinical wisdom of therapists, six categories were created:

1. Single with no children
2. Single parents
3. Partnered with no children
4. Partnered with children
5. Separated or divorced with no children
6. Separated or divorced with children

ANOVA was implemented to see if there was any significant difference between these six groups on self-perceived clinical wisdom. ANOVA showed a significant difference in therapist's self-perceived clinical wisdom based on their marital status and parental status combined [F (5, 3872) = 5.23, p < .001]. Scheffe's post hoc analysis further revealed that the group of therapists who were single and had no children had the lowest mean on self-perceived clinical wisdom (M = 1.87) and this was significantly lower than partnered parents (M = 2.02) and separated or divorced parent therapists (M = 2.07) at the .05 significant level. Thus, the group of therapists who were single and had no children were feeling significantly Less Wise

with their clients as compared to the partnered parents and separated and divorced parent therapists.

Therapist Quality of Life (Positive and Negative) and Emotional Well-Being

The DPCCQ assessed therapist's quality of life (QoL) by asking two questions:

1. How satisfying was the therapist's life at the present moment?
2. How stressful was the therapist's life at the present time?

These items were measured on a 6-point scale where 0 = Not at All to 5 = Very Greatly endorsed. In addition to these two questions, quality of life was assessed by asking a set of 11 questions that had both positive and negative items asking therapists to rate, on a 6-point scale, how much they worry about issues of financial security, health issues, concerns about relationship and intimacy, and a sense of belonging to a community.

To determine how each of these variables interact with QoL, an analysis of QoL was completed by using two independent variables: (a) wise in close personal relationships, and (b) wise with clients.

Table 27 shows that on average, therapists who felt Very Much Wise in their close personal relationships had a significantly higher level of current life satisfaction and significantly lower life stress. The therapists who felt Very Wise in their close personal relationships rated themselves as significantly higher in being able to express their private thoughts and feelings, having a sense of being genuinely cared for, having a satisfying sense of intimacy and support, having some moments of unreserved enjoyment, and having a sense of belonging to a meaningful community—which was significantly higher than other therapists who were lower in their self-perceived wisdom in close personal relationships.

Table 27. Self-Perceived Wisdom in Close Personal Relationships and Its Relation to Therapist Quality of Life (QoL)

Items Related to QoL	***F***	***P***	**Post Hoc [a]**
Able to freely express private thoughts and feelings?	30.14 (3, 3616)	<.001	**3** > 2 >0
Hassled by the pressures of everyday life?	6.32 (3, 3410)	<.001	**0** > 1, 2, 3
Moments of unreserved enjoyment?	18.28 (3, 3608)	<.001	**3** > 0, 1
A sense of being genuinely cared for and supported?	11.70 (3, 3607)	<.001	**3** > 0, 1
A sense of significant personal conflict, disappointment or loss?	1.66(3, 3606)	.174	**N/S**
A heavy burden of responsibility, worry or concern for others close to you?	1.05(3, 3607)	.369	**N/S**
A satisfying sense of intimacy and emotional rapport?	17.57 (3, 3612)	<.001	**3** > 1, 0
Worry about money or financial security?	4.27 (3, 3613)	.005	**0** > 1, 3, 2
Worry about your physical health?	2.37(3, 3607)	.068	**N/S**
You take sufficient opportunities to relax and refresh yourself?	34.39(3, 3610)	<.001	**3** > 2, 1, 0
Have a sense of belonging to a personally meaningful community?	12.56(3, 2735)	<.001	**3** > 1, 0
Current life satisfaction	27.09 (3, 3607)	<.001	**3** > 2 >1
Current life stress	7.21 (3, 3612)	<.001	**3** <1<2

[a] Levels of self-perceived clinical wisdom: 3 = Very Much Wise, 2 = Much Wise, 1 = Somewhat Wise; 0 = Not at All Wise
N/S= No significant difference

To examine if the self-perceived clinical wisdom of therapists relates to their QoL, ANOVA was completed for the 11 items in the scale. Results are presented in Table 28.

Table 28. Self-Perceived Clinical Wisdom and its Relation to Therapist Quality of Life (QoL)

Items Related to QoL	***F***	***p***	**Post Hoc** [a]
Able to freely express your private thoughts and feelings?	22.33 (3, 4057)	<.001	**3** > 2, 0, 1
Hassled by the pressures of everyday life?	3.21 (3, 3848)	.022	**N/S**
Moments of unreserved enjoyment?	20.33 (3, 4046)	<.001	**3** > 2, 0, 1
A sense of being genuinely cared for and supported?	11.13 (3, 4048)	<.001	**3** > 1, 0
A sense of significant personal conflict, disappointment, or loss?	.46(3, 4045)	.465	**N/S**
A heavy burden of responsibility, worry, or concern for others close to you?	.984(3, 4048)	.399	**N/S**
A satisfying sense of intimacy and emotional rapport?	14.27 (3, 4050)	<.001	**3** > 1, 0
Worry about money or financial security?	5.14 (3, 3693)	.001	**0** > 1, 3, 2
Worry about your physical health?	4.67(3, 4048)	.003	**0** >2, 1
Take sufficient opportunities to relax and refresh yourself?	33.82(3, 4050)	<.001	**3** > 2, 1, 0
Have a sense of belonging to a personally meaningful community?	16.83(3, 3157)	<.001	**3** > 2, 0, 1
Current life satisfaction	20.81 (3, 4050)	<.001	**3** > 2, 1, 0
Current life stress	7.87 (3, 4056)	<.001	**3** < 2,1

[a] = Levels of self-perceived clinical wisdom 3 = Very Much Wise; 2 = Much Wise, 1 = Somewhat Wise; 0 = Not at All Wise
N/S= No significant difference

Table 28 shows that on an average, therapists who felt Very Much Wise with their clients have a significantly higher level of current life satisfaction and significantly lower life stress.

Emotional well-being was assessed by asking therapists to describe their current emotional and psychological well-being on a 6-point scale where 0 = Quite Poor to 5 Being Very Good. To assess if therapist's emotional and psychological well-being was influenced by how Wise they felt with their clients, ANOVA was carried out. ANOVA showed significant

differences on levels of emotional and psychological well-being between the therapists who differ on self-perceived clinical wisdom F (3, 4049) = 25.43, $p < .001$. Scheffe's post hoc analysis further revealed that the group of therapists who felt Very Wise with their clients had significantly higher levels of emotional and psychological well-being (M = 4.01); this was significantly different from the other groups at the .05 level of significance. A similar trend was also seen when assessing the relationship of self-perceived wisdom of the therapist sample in close personal relationships with emotional well-being. A significant difference in the means was confirmed by ANOVA, F (3, 3602) = 32.17, $p < .001$. Therapists who perceived they were Very Much Wise in their interpersonal relationships also perceived themselves to have the highest emotional and psychological well-being (M = 4.12), which was significantly higher ($\alpha = .05$) than the therapists who felt Much Wise in their close personal relationships (M = 3.86). The therapists who felt Not at All Wise in their close personal relationships also reported the significantly lowest emotional and psychological well-being (M = 3.59).

Nationality

The analysis of the differences in therapists' self-perceived wisdom with clients based on their nationality was executed by ANOVA and post hoc Scheffe's analysis. Initial descriptive analysis was performed to get a lay of the land. Table 29 shows the results.

It is important to remember that data was collected by convenience sampling which meant that there were unequal number of therapists from each country. In addition, since the meaning of the adjective Wise was not operationally defined in the questionnaire, the possibility of the cultural understanding of the term being different in some countries could have influenced the way the therapists in each country responded to the question. ANOVA confirms that the

difference in the means of therapists from different nations is statistically significant F (11, 4113) = 27.8, $p < .001$. Countrywide analysis (multiple comparisons) is given in Appendix C.

Table 29. Self-Perceived Clinical Wisdom and its Relation to Nationality of the Therapist

		Wise with Clients				
		Not at All %	**Somewhat %**	**Much %**	**Very Much %**	**Total (N)**
Country of Residence	USA	2	9	49	40	649
	Canada	4	11	48	37	268
	UK	2	21	57	21	981
	Denmark	2	19	56	21	362
	Mexico	13	35	21	31	62
	Chile	8	36	51	6	144
	Malaysia	3	4	59	35	109
	Australia	4	29	50	17	982
	New Zealand	2	10	53	35	321
	Turkey	0	7	52	41	27
	Ireland	2	15	58	25	97
	Slovakia	5	20	64	10	78
Total	12	3	19	52	26	4125

Post hoc Scheffe's analysis revealed that the therapists from Turkey had the highest mean on self-perceived wisdom (M = 2.33), followed by therapists from the United States (M = 2.27), and then followed by therapists from Malaysia (M = 2.26). Therapists from Chile reported the lowest scores on perceived wisdom with clients (M = 1.54) at a .05 level of significance.

Summary

This chapter analyzed the practitioner characteristics (i.e., professional and personal therapists' characteristics) with reference to their levels of self-perceived wisdom with their clients. In the arena of *Professional Characteristics*, the following facets were analyzed:

Career level or years in practice: The results indicated that the therapists with the most years of practice perceived they were significantly Wiser with their clients than the ones with the least years of practice. This difference is statistically significant.

Experienced career development (to date): Therapists who perceived they were Very Much Wise with their clients also felt a much higher sense of professional growth and development once reflecting on their careers. This was significantly different from the therapists who felt Somewhat Wise or Not Wise at All with their clients.

Professional identity: Therapists in this study identified with six primary professions. Results indicated that there was *no significant difference* amongst the therapists who differed in their professional identity on self-perceived clinical wisdom ($\alpha = 0.01$). Social workers perceived they were Wiser with clients than the other professional groups with psychiatrists perceiving that they were Least Wise with their clients in comparison to other professional specializations.

Theoretical orientation: Theoretical orientation and its relation to self-perceived clinical wisdom with clients were analyzed at two levels: How much a therapist endorses a particular orientation (i.e., difference on the basis of salient affiliation with a particular theoretical school) and how a therapist's self-perceived clinical wisdom relates to having an eclectic or integrative stance toward theoretical influences. The results indicated that significant differences were evident among the therapists on how Wise they felt with their clients, based on their theoretical

orientation statistically ($\alpha = 0.01$). The results also indicated that therapists who reported that they were more eclectic or integrative also perceived they were Wiser with their clients, followed by the Moderately Integrative, Little Integrative, Somewhat Integrative, and Not at All Integrative, who felt the Least Wise with their clients in the sample.

Training and supervision: Didactic training was significantly positively correlated with therapists' self-perceptions of being Wise with clients. Supervision and its relationship with therapist's self-perceived clinical wisdom was examined at two levels. One, total years of supervision that a therapist had and two, the number of therapists that sought a particular therapist to be their supervisor. Years of supervision was significantly positively correlated with therapists' self-perceived clinical wisdom at $\alpha = 0.01$ level. The more the number of years of supervision, the Wiser therapists' perceived they were with their clients. On the second variable, the greater the number of therapists that sought a particular therapist for supervision, the Wiser the sought-out therapists felt they were with their clients.

Personal therapy (utilization and experienced benefit): A large part of the sample felt that personal therapy is important and should be required by all therapists (73%). In the sample, 88% had received personal therapy at some point of their lives. There was a statistically significant difference amongst therapists who had received personal therapy and those who had never had any personal therapy on how Wise they felt with their clients. Additional analysis showed that therapists who had experienced personal therapy as beneficial felt Wisest with their clients, as compared to the other groups. In addition, the groups of therapists who had the most extreme experience of personal therapy (i.e., felt most positively impacted by personal therapy and most

negatively impacted by personal therapy, in their own lives, were feeling Significantly Wiser with their clients as compared to the other therapists.

Experienced current development: Experienced current development was explored along two dimensions of growth and depletion, as experienced by therapists in the sample. The results showed a significant difference in the experience of current development as growth by therapists. Therapists who felt Very Wise with their clients had a significantly enhanced perception of their development as growth. This experience of growth was significantly higher than the other groups of therapists. Therapists also had significantly different experiences of current levels of professional development, based on their self-perception of wisdom with clients. However, the post hoc tests were not able to clearly establish which of the groups significantly differed from each other.

Next, the results on *Personal Characteristics* of therapists and their relation to therapists' self-perception of wisdom with clients are summarized.

Wisdom in close personal relationships: Therapists' responses to the perception of being Wise with clients and the perception of being Wise in close personal relationships were significantly positively correlated at $\alpha = .001$ level. There were significant differences between the means of the therapists on self-perceived clinical wisdom based on how Wise they felt in their close personal relationships. The therapists who felt Very Much Wise in their close personal relationships had significantly higher means on self-perceived clinical wisdom as compared to the other groups. The group of therapists who felt the Least Wise in their close personal relationships had significantly lower means on self-perceived clinical wisdom, as compared to the other groups.

Therapist's age and sex: The results of the analysis for the variable of age showed that the younger the therapist, the Less Wise they perceived themselves to be with their clients. The cohort of oldest therapists reported feeling Significantly Wiser with their clients than the younger therapists. No significant difference was seen among male and female therapists' self-report on how Wise they felt with their clients. Analysis using both age and sex and its relation to self-perceived clinical wisdom showed that senior adult men (60-90 years) felt Significantly Wiser with their clients than any other group. In addition, young adult women therapists (20-29 years) felt Significantly Less Wise with their clients than the rest of the therapist groups.

Therapist's marital and parental status: Therapist's marital status had a significant relationship with their perception of feeling Wise with clients. The group of therapists who marked their relationship status as Other had a significantly higher mean on feeling Wise with their clients. This was different from therapists who reported living with a partner (and who had the lowest mean), followed by single therapists, and then married or remarried therapists (who had the next higher mean). Parental status also had a significant relationship with therapists' perceptions of being Wise with their clients. Further analysis was done to see the interplay of marital and parental status with the research variable. The group of therapists who were single and had no children had the lowest mean on self-perceived clinical wisdom. This was significantly lower than partnered parents and separated or divorced parent therapists at the .05 significance level.

Therapist's quality of life (QoL) and emotional well-being: Therapist's QoL was assessed on the two factors of life satisfaction and life stress. On average, therapists who reported they felt Very Much Wise with their clients had a significantly higher level of current life satisfaction and

significantly lower life stress. Therapists who felt Very Much Wise in their close personal relationships had a higher level of current life satisfaction and significantly lower life stress. Therapists who felt Very Wise with their clients had significantly higher levels of emotional and psychological well-being, which was significantly different from the other groups at the .05 level of significance. The therapists who felt Not at All Wise in their close personal relationships also reported significantly lower emotional and psychological well-being.

Nationality: There was a significant difference on self-perceived wisdom with clients of therapists based on their country of residence. Therapists from Turkey had the highest mean on self-perceived wisdom, followed by therapists from the United States and Malaysia. Therapists from Chile had the lowest self-reported scores on perceived wisdom with clients.

CHAPTER SIX

DISCUSSION

This study examined the practice and professional correlates of self-perceived clinical wisdom in psychotherapists. It provided an exploratory study using data collected from therapists by the Society for Psychotherapy Research Collaborative Research Network (SPR/CRN). The instrument used to collect data was the Development of Psychotherapists Common Core Questionnaire (DPCCQ). The practice and practitioner variables of 4,139 therapists were examined in relation to therapists' self-perceived wisdom with clients.

The research results were tabulated in Chapters Four and Five. This chapter examines the results to distinguish the similarities and discrepancies in relation to existing research. The order of the discussion findings follows that of the presentation of findings in the results chapters. Therefore, the practice variables are discussed first, followed by the practitioner variables.

Self-Perceived Clinical Wisdom in Therapists and Associated Practice Variables

This section discusses the practice variables under two broad dimensions of *technical-instrumental* factors and *interpersonal-affective* factors. The technical-instrumental aspects of practice, which include treatment goals, clinical skills, difficulties in practice, and the coping strategies of therapists, will be discussed first. Then, the interpersonal-affective sphere, which includes the management of the therapeutic frame, relational manner of the therapists, therapists' in-session feelings, and therapists' intersession feelings is discussed.

Treatment goals of practitioners were assessed by a 16-scale item in the DPCCQ, which represent the top goals of predominant theoretical orientations in psychotherapy practice. Identifying treatment goals has been recommended in relation to client engagement, treatment planning, and outcome evaluation (Holtforth & Grawe, 2002; Wood & Mcmurran, 2013). Goals represent an important component of the triad that constitutes therapeutic alliance (goals, bond, and tasks; Bordin, 1955). The Top 5 endorsed goals of the therapists who perceived they were Wise with their clients were not ranked differently from those of the therapists who perceived they were Not Wise with their clients. Both groups reported developing a strong sense of self-worth and identity as their top most goal (endorsed by 60% of the sample). A similar result was seen in Orlinsky and Rønnestad's (2005) multisite, international study and Fraley's (2012) study on American transpersonal therapists. Self-worth and identity relate to therapeutic work that helps clarify personal strivings and desires and moves the individual toward individualism, inwardness (a preoccupation with one's inner life and affairs), and role differentiation (Orlinsky & Rønnestad, 2005). The focus on a personal sense of self and individual identity represents a distinctive hallmark of the current ethos (Orlinsky & Rønnestad, 2005). Therefore, it was not surprising that psychotherapists who are a product of these times and culture endorse this goal so widely. The next two commonly echoed goals also highlight the same point. Understanding feelings, motives, and/or behavior were endorsed by slightly less than half of the sample (48%) and helping clients recognize and change how they create their own problems was endorsed by 45% of the sample.

Research points to a difference in goals based on the intent of the therapeutic encounter. Goals focused on symptom alleviation differ from interpersonal goals, which differ from well-

being, existential goals—and which all differ from personal growth goals (Holtforth & Grawe, 2002; Mackrill, 2011). In this study, however, there was no difference between the Wise and Not so Wise on different goal categories. Even when it came to the least endorsed goals—namely, developing a more tolerant attitude toward others and developing the ability to better meet familial and social responsibilities, both groups endorsed these two goals the least. However, what is heartening is that the Top 3 goals represent a good mix of the intrapersonal reflection, awareness of feelings, and problem-solving approach. This triad captures the basic work of most psychotherapy orientations. In fact, the Top 3 goals are reflective of an integrative and holistic approach to working with clients.

Clinical skills are used by practitioners to work on the agreed upon goals with clients. More often than not, students are trained in skills that are common across all schools of therapy; for example, listening, questioning, adopting an empathic stand, and reframing. During graduate school, skills specific to a particular orientation(s) are developed. As with other skills, practice in addition to other personal factors determines proficiency. A somewhat artificial distinction has often been made between the technical skills and relational skills of psychotherapy, belying the deep synergy that exists between the two (Gelso, 2013). Ways of determining therapeutic skillfulness include examining the experts in the field (Rønnestad & Skovholt, 2013), measuring the quality of the alliance, and assessing client outcomes.

The therapists in this study who perceived they were Very Much Wise with their clients also marked themselves as significantly higher on all 12 clinical skills assessed in the DPCCQ. They reported more skills in utilizing theoretical understanding, a greater ability of engaging clients in a working alliance, and mastery over techniques and strategies of the practice of

psychotherapy. The therapists who perceived they were Very Much Wise with their clients reported feeling very confident in their role as a therapist. This confidence is significantly higher than therapists who felt Much Wise, Somewhat Wise, or Not at All Wise with their clients. When examining the higher-order factors that emerged from the factor analysis of the 12 items assessing wisdom, it was found that the Very Much Wise therapists perceived they had significantly higher basic relational skills, technical skills, and advanced relational skills.

Wisdom research has consistently pointed to the highly developed social intelligence, emotional intelligence, empathy, and interpersonal competence of wise people (Baltes & Staudinger, 2000; Glück & Bluck, 2013; Glück et al., 2005; Holiday & Chandler, 1986). Research on attributes of the therapists that support the working alliance also highlight the role of relational skills including utilizing the self, empathy, and an awareness of one's own emotional reactions (Ackerman & Hilsenroth, 2003; Nissen-Lie et al., 2010; Orlinsky et al., 2004). Studies on attributes of master therapists also highlight that master therapists are highly skilled in the domain of relational skills (Jennings et al., 2013; Rønnestad & Skovholt, 2013). The results highlight that wisdom in the general population and wisdom in psychotherapy are both an art and a science. Psychotherapy involves not only delivering of a technical input (interpretation, challenge, or question) but the knowing when and how to do it (Ryle, 2000). This combination of technical skills and advanced relational skills was reported by the Very Much Wise therapists.

Difficulties in practice cause distress and professional impairment and can adversely affect the process of therapy (Sherman & Thelen, 1998). Difficulties arise due to the nature of the clients being seen, high case load and work demands, and personal stress factors (Briggs &

Munley, 2008). The statistically significant study results indicate that the therapists who felt Very Much Wise with their clients perceived they faced the least amount of difficulties, as compared to the other therapists in the sample. The items where no clear difference emerged between the groups entailed two items dealing with therapist's feeling angered by factors in a client's life that prevented a beneficial outcome and therapist's feeling frustrated with a client for wasting the therapist's time. Again, there was a significant difference between the groups, but the test was not adequately powered to distinguish which of the groups significantly differed from the others.

Factor analysis of difficulties in past studies yielded three factors: *frustrating treatment case*, *negative personal reaction*, and *professional self-doubt* (Orlinsky & Rønnestad, 2005). Frustrating treatment case was defined by feeling distressed at not being able to affect a patient's life condition or feeling distressed over the conditions in a patient's life that make it difficult to move the work of therapy forward. The Very Much Wise therapists experienced less frustration over the nature of difficulties that they had no control over as compared with the other therapists with a lesser amount of self-perceived clinical wisdom. This finding is relevant as it highlights the importance of a therapist managing his or her own distress about a situation that he or she cannot influence. This emotional equanimity, which leads to the experience of distress but brings the therapist to an emotional middle ground with increased availability for the client, has been indicated as one of the differentiating qualities of master therapists (Jennings & Skovholt, 1999). The attribute of emotional equanimity is also associated with the ability of the therapist to manage his or her personal reactions to the client. The second higher-order factor of therapeutic difficulties explored involved negative personal reactions. The self-perceived, Very Much Wise

therapists had significantly lower difficulty in managing their negative emotions such as anger and frustration at a client from spilling into the session. Therapists who perceived they were Very Much Wise with their clients also reported experiencing (very few times) a lack of empathy, conflicts in personal values with clients, and an inability to maintain a proper attitude toward a patient. Study results show that the therapists who felt Very Much Wise with clients perceived they were more likely than other therapists to find something to like in a client and were able to withstand a client's neediness more than the other therapists. This finding is important as negative personal reactions (unable to find something to like in a client and unable to withstand the client's neediness) of the therapist lead to negative ratings on early patient-rated alliance measures (Nissen-Lie et al., 2010). Furthermore, it has been suggested that it might lead to premature closure or termination in therapy (Rønnestad & Skovholt, 2003). These results are supported by wisdom literature highlighting emotional regulation, empathy, compassionate relationships, and emotional equanimity (Bangen et al., 2013; Glück & Bluck, 2013) as characteristics of wise people. These results also tie-in with literature on master therapists that stresses emotional maturity and self-awareness of such therapists (Jennings & Skovholt, 1999).

The last higher-order factor that emerged from the factor analysis of the 20-items relating to therapeutic difficulties was the factor of professional self-doubt. Professional self-doubt is comprised of the therapist lacking confidence as a professional, being unsure if the work he or she does is beneficial for the client, not being able to sustain the momentum to move therapy forward, feeling demoralized by his or her inability to help a client.

The sampled therapists in this study who felt Very Much Wise with clients experience professional self-doubts less frequently. Professional self-doubt was the most commonly

experienced difficulty in one study on therapists by Orlinsky and Rønnestad (2005). These experiences, especially for beginning therapists, are a common and normative part of professional development (Rønnestad & Skovholt, 2013). The expectation is that there will be some self-doubts in the therapeutic work as this provides momentum for change and growth. Najavtis and Strupp (1994) reported that effective therapists are prone to be more self-critical, and report having made more mistakes in therapy than less effective therapists. In fact, Nissen-Lie et al. (2010, 2013) found that a moderate level of professional self-doubt was positively associated with a higher score on a client rated working alliance. They reasoned that maybe a therapist's disclosure of not-knowing reflects an attitude of humbleness and that the client may perceive that the therapist's self-disclosure of not-knowing to be respectful, thus strengthening the working alliance. Nissen-Lie et al. (2017) further worked on therapists' self-doubt and its correlation with personal factors such as self-affiliation [based on the model of Structural Analysis of Social Behavior (SASB) by Lorna Benjamin (1996), where self-affiliation is described as thoughts, behaviors, and emotions directed toward oneself]. Nissen-Lie et al. (2017) very aptly concluded their research by summing, "love yourself as a person, doubt yourself as a therapist" (p. 48). Levitt and Piazza-Bonin (2017) go as far as to define clinical wisdom as "the risk to not know" (p. 128). In this study, the Very Much Wise therapists experienced less frequent self-doubts, as compared to the other therapists. These results are contrary to research in the psychotherapy field and studies on wise people in the general population who are seen as humble, self-critical, and avid learners (Aldwin, 2009; Assmann, 1994; Redzanowski & Glück, 2013). This result warrants further research to explore associated experience, age, theoretical

orientation, and the nature of the professional difficulties of these therapists who felt Much Wise with their clients than other therapists.

To cope with the difficulties, therapists employed a wide-variety of coping mechanisms. Coping strategies were measured on an 11-point bidirectional scale with the results showing that therapists who perceived they were Very Much Wise with their clients also perceived they were using positive coping skills to deal with practice difficulties. One item, often a part of the positive skills repertoire, was not associated with Very Much Wise therapists. This item related to seeking consultation with more experienced therapists when in difficulty. The Very Much Wise clients were seeking less consultation with other experienced therapists when they perceived difficulties in sessions. In the past, factor analysis of these 11 items yielded four dimensions (Orlinsky & Rønnestad, 2005); seek consultation, revise or reframe the helping contract, avoid therapeutic engagement, and exercise reflective control.

In addition, a single scale of positive coping dimensions was created called *constructive* coping. The group of therapists who perceived they were Very Much Wise with their clients was significantly different from other therapist groups in their use of the coping strategies that cluster under the factors of *exercising reflective control* and *utilization of constructive coping* strategies. Feeling Very Much Wise with clients was associated with therapists' perceptions of using positive ways to cope with difficulties and exercising reflective control, which include strategies such as reviewing privately how a problem arose, trying to see the problem through different lenses to understand it better, containing one's negative feelings, and setting limits to maintain an appropriate therapeutic frame.

Reflective abilities have been positively correlated with wisdom in the general population and with the qualities displayed by master therapists in the psychotherapy literature. Wisdom literature clearly articulates use of reflective judgments, expertise in the skill of reflection, and the capacity to be curious and questioning about issues intrinsic to the personality of the wise individuals (Ardelt, 2004; Bluck & Glück, 2005; Clayton, 1976; Glück & Bluck, 2013; Hershey & Farrell, 1997). The Very Much Wise therapists in this study perceived they were also using some of these skills to cope with difficulties as they arose with their clients. They were able to look at issues from different theoretical lenses and contextual perspectives, interpret difficulties with the clients as issues to be processed (with their own selves and then with the client), and perceive that they were flexible in maintaining a therapeutic frame, given difficulties with clients.

The dimension of constructive coping includes problem-solving with the client, seeking consultation, and positive aspects of exercising reflective control. Interestingly, while the Very Much Wise group of therapists differentially perceived they employed constructive coping, they were not different from the other therapists on the aspect of seeking consultation when in difficulty. There can be a few possible reasons for this. Perhaps a senior group of practitioners was studied who did not feel the need to consult as much as a novice group of professionals might. It is also possible that a large number of these professionals are in settings such as a private practice setting that limits the immediate availability of sources in which to consult.

In past studies, constructive coping has been associated with Wise individuals. Ardelt (2005) found that wise individuals typically follow the motto, “if life gives you lemons, make lemonade” (pp. 11-12). She labeled this skill as reframing. Wise individuals reframe the problem

as a puzzle to be solved with curiosity, not dread. The wise individuals in Ardelt's study viewed problem-solving as starting internally with the individual accepting their feelings rather than blaming outside events. These wise individuals didn't allow themselves to be overpowered by crisis; instead, they employed a coping skill called "mental distancing" (p. 11). Wise people use mental distancing to calm emotions and to take control of him- or herself instead of trying to control the external situation. Sullivan, Skovholt, and Jennings (2005) referred to the skill of "objectivity" when describing the way master therapists deal with challenging therapeutic relationships (p. 61). Master therapists offer a new perspective, provide interpretations, set limits, and yet, become more engaging (collaborative) with the client. In addition, they "use the self" as an agent of change in the therapeutic relationship and readily accepts their emotions including fear (p. 51).

Self-Perceived Clinical Wisdom and Associated Interpersonal-Affective Correlates

The interpersonal-affective aspects of the therapist in the therapeutic space were studied in relation to therapists' perceptions of feeling Wise with clients. This included therapists' perceptions of how they managed therapeutic boundaries, their style of relating to clients, their feelings in-session, and intersession experiences with regards to the client.

Although no clear definition of *frame management* exists in psychotherapy literature, an agreement exists among practitioners and clients that there is a framework defined by parameters of time, self-disclosure, physical contact, nonsexual contact, and confidentiality that is managed by the therapist (Myers, 2004). Frames are not fixed or impenetrable. Terms such as elastic, creative, fluid, and extemporaneous have been used to describe the manner in which therapists adhere to these set of rules (Mahomed, 2008). The importance of keeping the frame arose from

psychodynamic work to allow the therapist and client to make sense of the transference reactions within the therapeutic relationship. The frame was also utilized to develop a set of rules covering agreement regarding time, space, the therapeutic relationship, payments, and therapeutic interventions. In this sense, the frame is a protective feature for the work of therapy, and frame transgressions and deviations constitute stress and strain for the therapeutic relationship (alliance). The confidence that a therapist has in his or her ability to manage (hold) a therapeutic frame in a flexible yet not elastic manner (Schröder & Orlinsky, 2011) determines how he or she feels about him- or herself as a professional.

Study results show that the therapists who felt Very Much Wise with their clients were more likely to schedule periodic additional sessions, let sessions run over, initiate or receive phone calls, have social or professional relationships outside of therapy, and willing to accept or initiate nonsexual contact. In the past, factor analysis of these 10 DPCCQ items yielded two factors: The arrangements of session or *frame flexibility*; and changing the tone of the sessions from professional to personal (possibly constituting transgressions) or *boundary laxity*. The self-perceived Very Much Wise therapists in this study showed significantly more frame flexibility, in comparison to the other therapists. This finding is supported by literature from the wisdom field that lists the attributes of wise people as: (a) good at making perceptive, sensible, and sound judgments (Baltes & Smith, 1990; Hershey & Farrell, 1997; Sternberg, 1985); (b) masters in the art of balance and flexibility (Glück et al. 2005); (c) experts in handling uncertainty—especially paradoxes and situations requiring flexibility (Brugman, 2000); and (d) calculated risk-takers (Oser, Schenker, & Spychiger, 1999) who are sensitive to contexts the dimensions of what, how, when, and with whom.

Literature on master therapists also attribute the characteristics of flexibility and contextualized therapeutic work to master therapists namely, that they embrace ambiguity (Jennings & Skovholt, 1999); have a strong sense of self, which helps in maintaining therapeutic frames (Harrington, 1998); have a flexible therapeutic attitude (Jennings et al., 2013); and are guided by accumulated wisdom (Rønnestad & Skovholt, 2013). Levitt and Piazza-Bonin (2014, 2017) refer to this quality of clinically wise therapists as *moral courage* that forms the basis of clinical wisdom and allows for ambiguity and personal sharing in the session without risking the safety of the therapeutic bond. Levitt and Piazza-Bonin (2014; 2017), state that wisdom goes beyond intelligence (which attempts to reduce ambiguity) in that it encourages questioning, pushing boundaries, and embracing ambiguity.

Thus, it is no surprise that the therapists in this study who reported feeling Very Much Wise with their clients also perceived they have the necessary flexibility, judgment, and strength of self to hold the therapeutic frame in a flexible manner. This flexibility allows for a therapeutic phenomenon to emerge and be explored and furthers the work of therapy rather than holding the frame too rigidly or too flexibly (elastic) thus creating situations for transgressing of therapeutic norms or boundaries.

The next interpersonal feature of therapists this study explored involved the *relational manner* of therapists. Relational manner refers to the therapists' experiences of themselves as therapists. Relational manner was measured on a 24-item scale in the DPCCQ, which correspond to four factors as seen from previous studies using the DPCCQ (Orlinsky & Rønnestad, 2005). The Very Much Wise therapists in this study perceived they were significantly higher on the relational attributes of affirming (which correspond to the qualities of acceptance, warmth,

tolerance, involved, nurturing, and friendliness) and effective (skillful, effective, and organized). This comes as no surprise as the qualities that correspond to the affirming dimension represent the common basic interpersonal skills across all theoretical orientations and modes of psychotherapy. These basic relational skills have provided the research focus in recent years as probably *the* factors that cause differences in client outcomes (Anderson et al., 2009; Anderson et al., 2015; Anderson et al., 2016; Schöttke, 2016). These skills, referred to as Facilitative Interpersonal Skills (FIS), influence the capacity of a therapist to enter a working alliance. Wisdom literature has been very consistent in talking about the role of FIS, such as sociability, proper interpersonal skills, warmth, humor, kindness, and compassion as characteristics of wise men and women (Bluck & Glück, 2005; Holliday & Chandler, 1986; Jason et al., 2001).

The second factor on which the self-perceived clinically wise therapists rated themselves significantly higher was the factor of effective associated with adjectives such as skillful, effective, and organized. Orlinsky and Rønnestad (2005), in an international study of over 5,000 therapists, found that therapists commonly experience themselves as skillful, effective, and organized. They also see themselves as agentic in the therapeutic relationship which is a positive trend shared with therapists in this study.

The feelings that the therapists experienced during the work of therapy is referred to as *in-session feelings*. Initial high correlations among the 20 adjective items that constitute this scale led to the creation of three statistical first-order-factors (using factor analysis) namely: flow, boredom, and anxiety (Orlinsky & Rønnestad, 2005). In this study, initial correlations revealed significantly positive correlations between self-perceived wisdom and feelings of inspired, engrossed, stimulated, available, calm, and focused. In contrast, significant negative

correlations were seen between self-perceived wisdom and feeling anxious, challenged, inattentive, tense, and unsure. The therapists, who perceived they were Very Much Wise with their clients, also perceived they experienced a significantly higher sense of flow in their practice. Flow represents a concept borrowed from the work of Mihaly Csikszentmihalyi (1996) and refers to a state of complete absorption in the task on hand. A person in the state of flow experiences engagement, fulfillment, and skillfulness, which enhances their intrinsic motivation to carry out the activity. The results indicate that the Very Much Wise therapists intrinsically enjoyed the process of doing psychotherapy with their clients, much more than other therapists in the sample.

Reflectivity on the part of therapists makes them aware of what is going on in the therapeutic space (transference, countertransference)—especially if there is a sense of flow or a sense of "stuckness" in sessions (Orlinsky & Rønnestad, 2005). Reflectivity is a key skill that the therapist must have to invite the client to be curious about the interpersonal dynamics of the therapeutic alliance. If the alliance serves as the vehicle for change, then reflection on the alliance gives the vehicle movement. Ardelt (2003) described reflectivity as the skill that raises an ordinary act or judgment to a wise one. The key characteristics that assist reflectivity are curiosity, care in using cognitive heuristics (not looking for simplification but opting instead for cognitive complexity), and what has been called deliberate inquiry (Skovholt et al., 1997). In order for flow states in therapy, there needs to be a healthy distancing of the therapist from his or her own needs to be available for the client; which allows free flowing or hovering attention to the observation of the relationship dynamic between the client and the therapists. In this study, the therapists who felt Very Much Wise with their clients also felt that they were significantly

more available in sessions. In addition, the Very Much Wise therapists felt least anxious in sessions, as compared to the other therapists.

This study also examined therapists for their *inter-session feelings* toward their clients. Inter-session feelings refer to the feelings that a therapist has toward a client in between two sessions. In Schröder et al.'s (2009) very aptly titled paper, "*You were always on my mind": Therapists' intersession experiences in relation to their therapeutic practice, professional characteristics, and quality of life*," they mentioned that the therapists' holding of the client in their mind is a relatively common occurrence. The group of therapists who reported feeling Not at All Wise with their clients expressed that they spent a significantly higher amount of time outside of sessions thinking how best to help resolve a client's problems and experiencing something similar to what a client has been feeling (recently, in-session, or even in-general). One explanation for this finding derives from the Schröder et al. paper just mentioned where they reported that inter-session experiences were more frequently reported by therapists who experienced more difficulties in practice, as these inter-session experiences were used to "cope constructively with those difficulties" (p. 50). Since therapists who felt Not at All Wise were also the ones having significantly more professional self-doubts, it could be that they were thinking about the clients between sessions as a means to cope constructively with the difficulties (professional self-doubts). The other explanation for the findings of the therapists who felt Not at All Wise experiencing something similar to what the client had in-between sessions could be related to their theoretical orientation. According to Schröder et al., psychodynamic therapists (based on the assumption that psychodynamic work is more process oriented and introspective) have a tendency to endorse more feeling related items in the scale measure for inter-session

experiences in the DPCCQ. The largest subsample of therapists who felt Not at All Wise with their clients is the analytic-psychodynamic group (N= 52). The nature of Analytic-psychodynamic work mandates processing feelings that arise as a result of the transference-countertransference dynamic. While some processing takes place within the session with the client, a large part of this processing happens outside the session (for the client and the therapist). This could be a possible explanation for the Not at All Wise therapists experiencing feelings similar to what the client has experienced in between sessions.

Before discussing the findings on the practitioner characteristics in relation to self-perceived clinical wisdom, a summary of the emerging picture of the self-perceived Very Much clinically wise therapist is presented. The self-perceived Very Much Clinically Wise therapists endorses goals similar to the Not Wise therapists. In addition, the goals that they both least endorse are similar. The self-perceived Clinically Wise therapists also perceive that they are significantly more skillful than the other group of therapists, that they have the least amount of difficulties in practice (including professional self-doubts), and that they are using significantly higher levels of reflective and constructive coping mechanisms. In terms of the relational or interpersonal-affective aspects of practice, the self-perceived Very Much Clinically Wise therapist report being able to hold the therapeutic frame in a flexible manner, allowing situational changes to the arrangement of the sessions in the service of the process of psychotherapy. The self-perceived Very Much Clinically Wise therapists express that their relational manner is significantly higher on attributes of affirming (warm, friendly, involved), and effective (skillful, effective, organized). In-sessions, these therapists perceive they are in the flow (feeling inspired and stimulated), available to the client, and feeling the least anxious or unsure in sessions.

These attributes closely approximate the personality and process of both master therapists and wise people in the general population except for the missing piece of humility, feeling unsure at times, and professional self-doubt. A wise therapeutic practice is ideally one in which there is a healthy amount of not-knowing, professional self-doubts, and humility to encourage self-reflection and professional growth. Macdonald and Mellor-Clark (2014) are of the opinion that clinicians work more effectively when they are more conscious of the challenges and ambiguity of their work rather than when they are blinded by their own competence. Humility and healthy self-doubt is the cornerstone of the personality of the master therapists too. The picture of the practice of wise therapists that has emerged in this study suggests that maybe these therapists who report feeling Very Wise with their clients may be lacking the necessary reflective practice essential for therapists to grow as professionals. One of the hypotheses could be that therapists have been lulled into a sense of complacency by their skillfulness to let self-doubts come into awareness (Macdonald & Mellor-Clark, 2014).

Self-Perceived Clinical Wisdom in Therapists and Associated Practitioner Variables

This section discusses the findings of the study linked to the person of the wise therapist namely, the professional correlates of the wise therapists, and the personal characteristics of the wise therapist.

To understand who the Very Much Wise therapist is professionally, *associated professional factors* such as years of professional experience, professional identification, theoretical orientation, years of training and supervision, personal therapy and therapists' own experience of professional development as growth or depletion were investigated.The therapists in this study with more *years of experience* (therapeutic work) felt Much Wiser with their clients,

representing a statistically significant difference. Specifically, therapists with more than 25 years of experience felt Very Much Wiser with their clients than the other therapists. Research supports that more years of experience leads to improvement in patient outcome and a drop in early terminations by clients (Stein & Lambert, 1995; Tracey, Orlinsky, & Rønnestad, 2005; Tracey, Wampold, Lichtenberg, & Goodyear, 2014). This could be a possible feedback that can be interpreted by therapists as indicative of being wise with clients. More recent research on the role of years of experience on client outcome reported data contrary to these results (Goldberg et al., 2016). Experience improved early termination but there was a very small but significant drop in therapist effectiveness (measured across time or across number of cases). There were some therapists who were consistently high performers and who continued to improve with years of experience. It could be a question worth exploring if it is the wise therapists who are consistently improving.

The influence of accumulated experiential learning on feeling more competent and confident as a therapist is not a surprise. But to explore if the wise therapists also perceive their career development (retrospectively) as growth, therapist participants were asked to reflect and look back on their development since they first began therapy. The Very Much Clinically Wise therapists felt that they had very greatly changed overall as a therapist. They perceived their development as progress or improvement, felt they were overcoming past limitations as a therapist, and realized their potential for development as a therapist. The perception of progress was significantly higher and different from the other therapists in the sample. In comparison, the group of therapists who were feeling Not at All Wise with clients perceived their career development as a decline or impairment. This feeling of decline was significantly higher

compared to the other groups of therapists. In wisdom literature, life satisfaction has been related to feeling wise (Grossman, Na, Varnum, Kitayama, & Nisbett, 2013; Krause, 2016; Le, 2011).

The practitioners of psychotherapy are trained professionally by different fields. To study if there was a difference in self-perceived wisdom of psychotherapists based on their professional affiliation and identification, the levels of self-perceived wisdom of therapists who identify with different professional specialties were compared. The therapists whose professional orientation was social work perceived they were significantly Wiser with their clients as compared to the therapists of other orientations. It is also important to point out that there were only 201 social workers in the sample, which is approximately 5% of the sample as compared to psychologists, which were approximately 39% of the sample. This finding would be more significant if the number of social workers in the sample were increased.

A concept related to professional identity is the theoretical identity of the psychotherapist. Different *theoretical orientations* have different understandings of human development and therefore, different approaches to working with clients. Therapists within orientations differed significantly from each other on how wise they were feeling with their clients. The transpersonal therapists were feeling significantly wiser and the psychodynamic therapists were feeling Less Wise. However, what stands out in the study results is that most therapists who perceived they were wise with clients had an eclectic or integrative orientation to working in their work. In addition, therapists who described themselves as Least Integrative were feeling significantly Less Wise than other therapists in the sample. This finding is supported by literature on master therapists, which concludes that master therapists across orientations share similar characteristics, especially during key moments of psychotherapy (Eels, 1999). They

recognize the limits of each school of psychotherapy and can be flexible and inventive in their clinical interventions (Rønnestad & Skovholt, 2013). Master therapists are able to hold on to their understanding of how change should unfold (their theory and understanding of what went wrong and how it should be fixed). They instead privilege clients' values and align themselves to the clients understanding of how change should occur. However, master therapists are quick to change this dynamic if they feel that what the client wants can be detrimental to the client's safety (Williams & Levitt, 2007). Levitt and Piazza-Bonin (2017) studied 17 therapists who had been nominated as wise by their peers. These 17 therapists highlighted the role of exposing students to various theoretical orientations including supervision by a therapist from a different orientation than the student. In addition, these therapists advised future practitioners to "… [work] with diversity, conceptualize cases with appropriate complexity, and make sense of the literature suggesting equivalence across orientations" (p. 134). Scaturo (1994) reported that psychotherapists in each of the major traditions of psychotherapy have found formal methods and protocols to be constraining and limiting to adequately address the range of clients seen in a clinical context.

The therapists who had more *years of training* felt Significantly Wiser with their clients, as compared to therapists with less training years. Therapists at all career levels attribute their growth to formal training and experiences such as family relations and personal therapy (Hill & Knox, 2013). Trainee therapists attribute confidence, enhanced self-awareness, better use of therapeutic techniques, and more therapeutic flexibility to training (Hill et al., 2015). However, training effects are not easy to investigate, since psychotherapy training can mean different things based on a therapist's nationality, theoretical orientation, profession, and interactions

(Rønnestad & Ladany, 2006). Finally, some studies show that training and outcome may not be related (Jacobson, 1995). So before drawing any definitive conclusions, it might be prudent to distinguish the nature of the training that the therapists are referring to when they say *years of training*.

Supervision has consistently been perceived by therapists as a valuable influence on their development, even more so than academic training (Orlinsky, Botermans, & Rønnestad, 2001; Orlinsky & Rønnestad, 2005). In psychotherapist development, supervision has been considered by some theorists as the single most important factor contributing to training effectiveness (Gonsalves & Milne, 2010) by enhancing treatment skills and personal development. Psychotherapy supervision has been viewed as "an educational sine qua non, in the making of the psychotherapy practitioner" (Watkins, 2014, p. 142). In the study, there was a positive correlation between feeling wise with clients and supervision. The more supervision a therapist had, the wiser he or she perceived him or herself to be with the client. However, an interesting finding emerged when partialing out the effect of years of practice or total years of didactic training, a negative nonsignificant relationship was seen between wisdom and total years of supervision. This finding implies that the relationship between supervision and wisdom is mediated by years of experience that a therapist has been in practice, as well as the years of didactic training he or she has had. This finding supports the conclusions of the ISDP study (Orlinsky & Rønnestad, 2005), which clearly showed that major influences on psychotherapist development are experienced with clients, supervision, and therapists' personal life experiences. Any conclusions regarding perception of feeling wise with clients and its relationship to training,

years of practice, and supervision, should be drawn taking all three factors into account as assuming a linear relationship does not do justice to this complex relationship.

The next set of results highlight that the more supervision therapists in this study had *given*, the Wiser they felt with their clients. Therapists who had supervised more than 25 therapists in their professional career were feeling Significantly Wiser than other therapists in the sample; while those therapists that had not supervised any other therapists felt the Least Wise with their clients. Theorists have remarked that the therapist and supervisor experiences are very different; being a good therapist does not automatically mean that a person will be a good supervisor and vice versa (Rubinstein, 2008). However, both activities point to a reflective, interpersonally vulnerable, self-aware, not-knowing stance, which relates to wise persons in the general public (Krause, 2016). The more a therapist is sought for supervision, the more opportunities it creates for the therapist to be reflective and cognitively challenged, which could possibly translate to the therapist feeling he or she is Wiser with clients.

Skovholt and Starkey (2010), while reflecting on the development of therapeutic expertise, stated "excellence as a practitioner mainly involves developing, at a very high level, as a person" (p. 126). This path of becoming a better person represents a life-long journey, with no clear path or certainty of outcomes. One of the ways to walk the path of personal growth and maturity involves the practitioner being in personal therapy. *Personal therapy* gives space for reflection, opens opportunities to learn from another professional, and creates opportunities to integrate the personal into the professional so that the practitioner can bring their whole being into the therapeutic space (Orlinsky et al., 2011). Seasoned therapists mark their own psychotherapy as an important arena of learning how to do therapy (Rønnestad & Skovholt,

2001). This study examined the relationship between personal therapy and therapists' perceptions of feeling wise with clients by assessing the number of therapists who have utilized personal therapy in the past and the impact of that on therapist development.

A large part of the sample (88%) utilized personal therapy at some point in their lives; one-fourth of the sample was still utilizing personal therapy. One-third of the sample felt that personal therapy was important and should be required for all therapists while another 20% felt that personal therapy was desirable, but should not be required. There was a significant difference among the therapists who had received personal therapy and the therapists who had not in how wise they felt with their clients. The group of therapists who reported most impact (benefitted most) from utilizing personal therapy were the ones who reported feeling Very Much Wise with their clients. These results are in agreement with Levitt and Piazza-Bonin's (2014) study of clinically wise therapists. A common feature across the clinically wise therapists was the practice of introspection and engaging in emotional work that they as therapists expect their clients to do. Twelve of the seventeen wise therapists in their study highlighted the route of personal therapy to engage in self-reflection and introspection to hone their skills of empathy, vulnerability, and relational connectedness with their clients. In conclusion, it is evident that a large number of the therapists in the sample are committed to their personal and professional growth as is evidenced through their utilization of personal therapy.

To further explore the arena of *professional growth*, therapists in this study were asked about their *current experience* regarding their own development on a 12-item scale. The results show that the majority of the sample participants are currently experiencing their growth as progress while 1% of the therapists experience it as a decline or impairment. Two thirds of the

sample feel they are becoming more skillful and are deepening their understanding of therapy. A large percentage of the sample reported a sense of growing enthusiasm about doing therapeutic work.

In previous research (Orlinsky & Ronnestad, 2005), two factors were created statistically; namely, *currently experienced growth* and *currently experienced depletion*, to capture the essence of therapists' ongoing change and development. A majority of the participating therapists are experiencing their development as growth while a very small percentage is experiencing their development as decline or impairment. Further analysis to understand the relationship between self-perceived clinical wisdom and therapists' experiences of their career development as growth or depletion revealed that the therapists who felt Very Much Wise with their clients were also experiencing their career development as growth in a significantly higher manner than other therapists in the sample. This implies that the self-perceived clinically wise therapists are currently experiencing their professional growth in a positive direction, feeling enthusiasm about doing psychotherapy, deepening their understanding of psychotherapy, feeling more skillful, and overcoming past limitations as a therapist. This aspect of therapist development ties in with the therapist's positive view of their perceived career development.

Self-Perceived Clinical Wisdom and Associated Personal Characteristics of Therapists

This section discusses the personal characteristics of the therapists who perceive that they are Very Much Wise with their clients. The attempt is to delineate the personal variables (such as age, sex, marital status, parental status, and nationality). In addition, wisdom in close personal relationships and therapists' quality of life and emotional well-being will be addressed.

Therapist self-perceived wisdom was studied in relation to therapist *wisdom in close personal relationships* (intimate relationships). Study results show that feeling wise with clients and feeling wise in close personal relationships was positively correlated. Therapists who perceive they are Very Much Wise with their clients also felt Significantly Very Much Wise in their close intimate relationships, while therapists who are feeling Not at All Wise with their clients also perceive that they are Not at All Wise in their close personal relationships. Wisdom literature and philosophical thought has pointed to the existence of conceptually different types of wisdom that may have a common core but are different. Recent research from the wisdom field again points to the Aristotelian concept of practical versus philosophical wisdom and personal wisdom versus general wisdom (Mickler & Staudinger, 2008). A recent study (Westrate, Ferrari, & Ardelt, 2016) tried delineating prototypes of wisdom (such as practical, philosophical, and benevolent wisdom), which relate to the transcendental attributes of wise people or the pragmatic attributes (like leaders of countries for example) and the emotional-transcendental attributes of others such as Mahatma Gandhi or Mother Teresa. Others researchers debate if wisdom in one sphere is possible without it trickling into other arenas of life. If this type of wisdom does not, then it may not represent true wisdom. The results of the present study show that the perception of being wise with clients and the perception of being wise in close personal relationships was very significantly positively correlated (r =.65) yet, there were some therapists who felt wise in their close personal relationships and did not feel wise with their clients (n=13). It is interesting to note that not a single therapist in this study felt Not at All Wise in close personal relationships but Very Wise with clients. Twenty percent of the sample reported feeling Very Wise with clients and in their close personal relationships as well.

Further analysis revealed that the group of therapists who felt Very Much Wise with clients also felt Significantly Wiser in their close personal relationships. Since wisdom represents such a complex variable with many factors working together to make a person feel wise, any causal attributions are difficult to make from this result. It would not be prudent to assume wisdom leads to better intimate relationships or better intimate relationships lead to wisdom. It can, however, be concluded that good interpersonal skills assist in the navigation of relationships in general and as previously discussed, the therapists in this study who felt Very Much Wise with clients perceive they have very high basic interpersonal skills and high advanced relational skills.

The concept of Facilitative Interpersonal Skills (FIS) and its influence on client outcome has been gaining ground in recent psychotherapy research studies (Anderson et al., 2009; Anderson et al., 2015; Anderson et al., 2016; Schöttke, 2016). Facilitative Interpersonal Skills consist of a composite of relational skills such as warmth, empathy, and persuasion, which have been linked positively to greater symptom reduction in clients and differential effectiveness of therapists (Anderson et al., 2015). It would not be a stretch to assume that these skills also underlie successful management of close intimate relationships. Common factors such as good interpersonal skills, compassion, reflection, humility, empathy, and affective stability that underlie psychotherapy relationships may also translate into *better* relationships outside of the therapy sphere. Skovholt and Starkey (2010) propose that therapist's personal life can both distort as well as illuminate the professional practice of the therapist (p. 129). It is important to keep in mind that practitioners are human and therefore, not immune to the harsh realities of life. In fact, suffering and loss at a personal level can help a practitioner understand grief in their clients. Furthermore, it has the capacity to make the therapist more empathic. Thus, it is possible

that the experiences in close intimate relationships inform the practice of the therapist in a positive way only if the therapist is willing to be reflective and learn from it (e.g., in personal therapy). The flip side consists of therapists who experience that they are Very Much Wise in practice and become complacent with clients and their personal relationships.

Age and wisdom have been closely related in people's minds in the general population. The images that people carry in their head about wise people is generally of a much older person. However, most empirical evidence is not unequivocally supportive of such claims (Baltes et al., 1995; Webster 2003, 2007). In psychotherapy literature, the therapist and age have been looked at by two very significant studies—the Minnesota Study (Skovholt & Rønnestad, 1995—updated in Rønnestad & Skovholt, 2013) and the SPR/CRN study (Orlinsky & Rønnestad, 2005). Both these studies point to senior therapists feeling more spontaneous, retaining enthusiasm for doing the work of therapy, feeling more secure, becoming more flexible, being less self-critical, being more realistic about what could be obtained through therapy, and being more accepting of their limitations as therapists (Orlinsky & Rønnestad, 2015). While more chronological years can bring a mastery over the professional developmental tasks, it can also lead to therapist cynicism and burnout. However, the group of senior therapists sampled who feel wise and effective experience their career growth as positive. In this study, senior therapists (> 75 years) felt Much Wiser with their clients than therapists who were 60-75 years; and these therapists perceived they were Significantly Wiser with clients than the youngest group of therapists (21-35 years). The relationship between feeling wise with clients and age remains significantly positive even when partialing out any effect of years of experience. The results are supported by Orlinsky and Rønnestad's study in which therapists in the 60-90 age group felt Significantly Wiser than

therapists in lesser age groups. It could be that senior therapists similar to those in Rønnestad and Skovholt's (1995) study had developed an attitudinal optimism to handle negative emotions and deal constructively with difficulties. Rabu (2014) reported that senior therapists become more tolerant and humble with increasing age, approximating the attributes of wise people in the general population.

A majority of therapists in the study were women (70%) and 30% of the therapists were men. No significant difference was seen among women and men therapists with regard to self-perceived clinical wisdom. A large meta-analysis of 64 studies concluded that the *sex* of the therapist did not predict outcome for either male or female clients (Bowman, Scogin, Floyd, & McKendree-Smith, 2001). Sex of the therapist is neither related to process nor outcome, even across different types of therapies (Staczan et al., 2017). Wisdom is conceptualized in a similar manner when it comes to gender (Staudinger & Glück, 2011). Wisdom is typically not seen as a quality that is stereotypically male or stereotypically female, on the contrary, the wise men and women are often more likely to be androgynous (Orwoll & Achenbaum, 1993). To take this analysis further, four groups were created in the analysis (based on age and gender) to explore if a particular therapist-gendered group that was based on age was associated with feeling differentially wiser with clients. The results show that the senior adult male therapist group (60-90 years) perceived they were Significantly Wiser than the other groups based on gender and age. It is also noteworthy that the group of young adult women therapists (20-29) felt Significantly Less Wise as compared to the other therapists in the sample. The influence of societal factors in explaining these results cannot be denied. Internalized societal perceptions could be one reason for the results as most images of wise people in popular culture are of older

men. When men and women are asked to report their experiences of being wise, men often report job-related experiences while women report family-related or illness and death-related experiences (Glück et al., 2005). Young adult women felt Significantly Less Wise on both Feeling Wise with clients and Feeling Wise in their close personal relationships, as compared to the other therapists.

Personal experiences such as attachments, losses, marriage, and children affect the personal life of the psychotherapists and contribute to their learning as professionals (Skovholt & Starkey, 2010). The humaneness and vulnerability of the therapist as a person (in their personal life) makes the practitioner more empathic with clients. However, personal experiences can have a positive as well as adverse effect on the therapeutic relationship. In cases where the therapist has not worked through his or her challenging experiences, these experiences may permeate into the therapeutic space adversely influencing the relationship between the client and the therapist. This is the reason why literature on therapist development and wisdom stresses *reflection* as an important skill for an effective therapist and wise person to have.

The therapists in this study belonged to 12 different *nationalities*. The majority of the sample (80%) was from English-speaking countries such as the United Kingdom, Australia, the United States, Canada, New Zealand, and Ireland. The other 20% of the sample consisted of therapists from Denmark, Chile, Mexico, Turkey, and Slovakia. Wisdom researchers have pointed to differences in conceptualization of wisdom based on culture, mainly referring to the differences in Western and Eastern conceptions of wisdom (Takahashi & Bordia, 2000; Takahashi & Overton, 2005). The western conception of wisdom is more cognitive or knowledge based while the eastern conception is related to integration of cognition and affect (Staudinger &

Glück, 2011). In this study, since the term *wise* was not defined, there could be a difference in the way wise was understood by therapists from different countries which could have influenced their responses to the question on *wise with clients*. The results show that the therapists from Turkey (*n*=27) perceived themselves to be Very Much Wise with their clients. This difference was statistically higher than the next set of therapists who were from the United States (*n* =649). Therapists from Malaysia (*n* =109) were behind therapists from the United States, with the therapists from Chile feeling the Least Wise with their clients (*n* =144). It would not be prudent to draw conclusions from the data on nationality, given the variability in sample sizes and the lack of an operational definition of the term *wise* in the DPCCQ.

Marital status was examined by looking at therapists who were single, married or remarried, divorced or separated, widowed, partnered, single; and an open category called *Other*. Interestingly, the therapists (*n* =46) who chose the open category of Other over the other stated categories felt they were Significantly Wiser than the therapists whose marital status was defined in the sample. It would be worth investigating what these therapists mean by Other when they define their marital status to draw conclusions. Among the groups of Other therapists, while no significant difference was seen on how wise the therapists felt they were with their clients, the group of married or remarried therapists had the highest mean on Feeling Wise with clients, followed by the therapists who were single. The group of therapists who were partnered perceived they were Least Wise with their clients. Therapists' *parental status* were examined in order to study the personal life of the therapist and its influence on Feeling Wise with clients (together with the marital status of the therapists). The results showed that the therapists who were single and had no children felt the Least Wise with their clients. This difference was

significantly lower than the partnered parents and the divorced or separated parents. From the results, it seems that the experience of having children added to the practitioners practice in a way that made them feel Wiser with clients.

Well-being has been associated with wisdom since philosopher Aristotle's time, who coined the term *eudemonia* to refer to a condition of flourishing and completeness that constitutes true joy and for which possession of wisdom is a prerequisite. Brugman (2006) noted that in the west, well-being is generally thought of as a consequence of wisdom. Csikzentmihalyi and Rathunde (1990) view wisdom as a personally rewarding and meaningful experience that provides some of the highest joys to mankind. This study examined the *emotional and psychological well-being* of therapists and its relation to Feeling Wise with clients. The therapists who were feeling Very Much Wise with their clients reported a significantly higher level of emotional and psychological well-being as compared to the other therapists in the sample. This result is supported by studies which posit that, "wisdom exerts its influence on well-being primarily through positive affect" (Etezadi & Pushkar, 2013, p. 947). Wise people are engaged in meaningful activities that give them satisfaction and happiness (Helson & Srivastava, 2002). By choosing such activities that have a sense of coherence, purpose, and value, wise people are able to decrease the distress and anxiety associated with tasks that are not personally meaningful. They also have a sense of perceived control over their immediate environment and use constructive coping to deal with negative emotions. Ardelt (2005) reported that wise individuals are able to overcome hardships and crisis in life, using them as opportunities for growth, greater sympathy, and compassion. Emotional and psychological well-being is directly linked to *quality of life*, especially factors such as social connectedness, health, productivity, and enjoyment of life

(Seligman, 2004). This sample studied the quality of life of therapists using an 11-item scale that had items related to health, relationships, expressing affect, and concerns about finances. Past factor analysis of these items yielded two factors: a positive factor called *life satisfaction* and a negative one called *life stress*.

The self-perceived Very Much Wise therapists had a significantly higher level of current life satisfaction and significantly lower life stress. For example, therapists: (a) were able to enjoy moments of unreserved joy, (b) had a significantly higher sense of being genuinely cared for and supported, (c) had a significantly higher sense of intimacy and emotional rapport, (d) had a sense of belonging to a personally meaningful community, and (e) took adequate self-care (work-life balance).

This finding is supported by literature on wisdom, which confirms that wise people are happier because they understand themselves and their environment and this results in a successful navigation of life (Etezadi & Pushkar, 2013). Furthermore, they are able to balance personal development with forming meaningful relationships and meaningful goals (Steger, Oishi, & Kashdan, 2009). This aspect also ties in with the Very Much Clinically Wise therapists feeling Significantly Wiser in their close personal relationships. The therapists who felt Very Much Wise in their close personal relationships also perceived a significantly higher level of life satisfaction and a significantly lower level of life stress, as compared to other therapists in the sample. The therapists who were Not at All Wise with clients were experiencing the highest amount of stress around issues of personal health and financial security. Paid employment has been shown to be critical to the well-being of individuals as it gives access to resources and

fosters satisfaction and meaning-making.[3] Wise therapists are able to balance their needs for individual growth with needs for interpersonal satisfaction.

Converging the Findings

The therapists in this study who perceive that they were Very Much Wise with their clients also experienced a work pattern that has been labelled *healing involvement* in past research (Orlinsky & Rønnestad, 2005). These therapists experienced themselves as affirming, involved, and committed to their clients. They report being engaged with their clients using a high level of relational skills (technical and advanced relational skills). In addition, they experience: a sense of motivation, enthusiasm, and focus in work, which has been labelled flow; very few difficulties in sessions; and when they do experience difficulties they are able to cope with those difficulties in a constructive manner. This pattern of healing involvement with very little stressful involvement is indicative of these therapists having an effective practice. In terms of professional development, therapists who felt Very Much Wise with clients were able to reflect on their careers with a sense of satisfaction and a feeling of growth. Furthermore, they felt that they overcame their past limitations as psychotherapists, had grown over the years, still felt empathic with clients, and had a sense of positive work morale.

The therapists who felt Very Much Wise with their clients had more practice experience with clients, had more training than other therapists, and were able to access a broad knowledge base besides their own theoretical focus. Most of them identify themselves as integrative or eclectic. These therapists have received and given more supervision than the other therapists, as well as received personal therapy (experiencing it as most beneficial).

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[3]In psychology, **meaning-making** is the process of how persons construe, understand, or make sense of life events, relationships, and the self.

The personal characteristics associated with therapists who felt Very Wise with their clients is being: older, a parent, and feeling very wise in close intimate relationships. The therapists who perceived they were Very Wise with their clients have a high sense of emotional and psychological well-being which adds to a higher quality of life. In keeping with wisdom literature and literature on master therapists, the expectation was that these clinically wise therapists would also display humility and professional self-doubt, and seek counsel when in professional difficulties. These attributes were displayed at significantly lower levels by the therapists who felt Very Much Wise with their clients. It is worth reflecting on if the confidence associated with Feeling Wise with clients was making the practitioner unaware of professional doubts. An alternate hypothesis suggests that confidence could be a protective defense against self-doubts, which can be threatening to a therapist's ego.

Interpersonal vulnerability lies at the heart of relationships (Levitt & Piazza-Bonin, 2014). Yet, it requires a strong and benevolent sense of self that allow these doubts to be used in the service of the client (Nissen-Lie, et al., 2017). These professional self-doubts are important in providing impetus to seek further knowledge and grow. In spite of the absence of these doubts, the therapists in this study experienced high professional growth. It is worth questioning and investigating what motivates these therapists to seek professional growth avenues and experiences. Future research can try to determine if therapists who perceived they are clinically wise are just clinically competent and effective. The self-perceived wise therapists in this study had training and knowledge and skills that are both relational and instrumental. In keeping with the wisdom literature, wise therapists have the cognitive and relational expertise associated with wise people in the general population. An important aspect of wise people consists of affect

management. The Very Much Wise therapists in this study reported a high level of emotional equanimity with clients along with the ability to manage their negative emotions toward clients in sessions. The Very Much Wise therapists also highlighted the benefits of reflective spaces, such as personal therapy and supervision. They were able to be integrative and draw from various theoretical perspectives in their approach to doing therapy. Even in their personal lives, these therapists had a sense of emotional and psychological well-being and high quality of life. In addition, wise therapists have the ability to form and maintain meaningful relationships. Some of these relationships may be intimate, since therapists also feel Significantly Wiser in their close personal relationships. In conclusion, therapists who felt Very Much Wise with clients also perceived they have high cognitive, emotional, and relational skills; they utilized opportunities to be reflective and found them beneficial. However, at this point, these therapists did not perceive themselves to have any doubts about what they do professionally; they were minimally unsure about themselves in practice and hardly ever sought counsel from others when difficulties in their practice arose.

Strengths and Limitations

The most challenging aspect of this study was defining what wisdom is in general and what clinical wisdom in psychotherapists entail. Since wisdom is a broad concept studied in many contexts with definitions of different fields converging only partially, narrowing down the field of study was challenging. This challenge implies that readers should generalize the results of this study to other fields cautiously since this study explores wisdom only in the context of psychotherapists and their practice. While literature on effective therapists and master therapists has been used as the conceptual basis for this research, it may be that the clinically wise therapist is very different from an effective therapist or master therapist. In this study, while a range of correlates of the wise therapist have been established, it is doubtful that they will all be present in the same therapist at all times; in that sense, perhaps there is no wise therapist or it is a very rare entity (which is similar to wise people in the general population). The findings of this study should not be conflated with what therapists actually *do*; this is what the therapists perceive they do. However, studies based on the DPCCQ data have shown association between therapist self-appraisals and patient-outcome (Heinonen et al., 2012, 2013; Nissen-Lie et al., 2010; Nissen-Lie, et al., 2017).

A strength and a limitation of this study involved the use of secondary dataset (i.e., data that was previously collected and not specific to the research aims of this study). The advantage of secondary data involves access to a large and varied sample with many variables that provide sufficient statistical power to detect relatively small real effects and implement many statistical analyses. In addition, the factor structure of the DPCCQ has been replicated in many studies across different subpopulations (see Appendix B), which assists in drawing generalizations

across therapists differing on nationality and professional backgrounds. The disadvantage is the inability to change variables, add instructions, or include new variables. Further, the data collected by the DPCCQ in the ISDP has always been voluntary, this means that the sample is not representative and in fact, might be a self-selection bias, with practitioners more invested in their development participating in this study. Last, the data for this study is cross-sectional while the validity of a variable, such as wisdom, is often established across time. A longitudinal study that follows therapists across a significant part of their careers would be required to determine if self-perceived wisdom with clients is a constant feature of the therapists' professional identity or not.

Despite its limitations, this study presents the first empirical study using quantitative analysis that connects clinical wisdom to actual practice and practitioner variables. It is good to have a grand theory of clinical wisdom based on expert opinions, but to see its embodiment in an international sample of over 4,000 therapists bridges theory, research, and practice. This study moves forward what wise therapists do, or researchers should think they do, to what therapists perceive they do and who they are as people and professionals. In addition, through this study, some correlates of wise therapists, which detract from existing literature, have also been identified. These discrepancies provide important guidelines for the training and supervision of therapists.

Implications

Some suggestions for the training and supervision of practitioners include the following:

1. A broad theoretical framework is critical component of psychotherapy training to help trainees evaluate the pros and cons of each theory and be flexible and pragmatic

in their work with clients. In this study, an integrated or eclectic perspective was associated with therapists' perceptions of being wise with clients.

2. Personal therapy for therapists in training should be mandatory. Not only is it correlated with therapists feeling wise with clients, it makes therapists more empathic with their clients. Personal therapy helps therapists be less narcissistically fragile and more vulnerable interpersonally; qualities which would help them build better relationships with their clients and grow as therapists.
3. Students (trainees) should be taught ways to monitor their own practice in the future. In this study, almost 75% of therapists were not currently in supervision; meaning, there was not an external watch on if they were doing well as practitioners, if they had a sense of healing involvement in their work or were heading for stress or burnout. What might be helpful in the future for practitioners is if, as part of their training, trainee psychotherapists were taught how to observe if a sense of healing is evident in their work for those times when these practitioners see themselves moving toward stress and eventual burnout.
4. Teaching students and trainees the skills of deliberate practice and reflection is essential. Recent research with psychotherapists has highlighted the value of deliberate practice (Chow et al., 2015). Deliberate practice domains that have been linked to highly effective therapists include reflecting on difficult cases alone, mentally running through past sessions, and reflecting on what to do in future sessions. Teaching deliberate practice and reflection, in addition to cognitive and relational skills to trainees, could be useful in building wise and effective practitioners.

5. Continuing supportive supervision should be ensured not only for beginning therapists but even early career therapists. Supervision has been related to therapists' perceptions of feeling wise with clients, as per this study. Continual supervision makes therapists humbler (a quality not seen much in the very wise therapists in this study) and pushes them to grow as practitioners. Supervision also offers opportunities for skill development and space for therapist to be more vulnerable.
6. In this study, both technical and relational skills were associated with therapists perceiving they were wise with clients. Psychotherapy research has also shown that the core sets of interpersonal skills, such as warmth, encouragement, openness, and empathy are related to client outcomes. Therapists who have these core skills continue to improve and grow significantly over the years, as compared to therapists who have less of these skills to start with. It has been suggested in the past (Anderson et al., 2015) and is a suggestion of this study, to systematically use these relational skills as selection criteria for psychotherapy programs.
7. Wisdom is a meta-cognitive variable, which comprises most qualities shared by master therapists. Teaching wisdom skills (using vignettes such as the Berlin wisdom school or wisdom tasks as suggested by Sternberg) could be included in the syllabi of beginning therapists to make them comfortable with dialectical thought, dilemmas of human existence, and ambiguity.

Suggestions for Future Research

This study documents an initial attempt to explore the correlates of self-perceived clinical wisdom in therapists. The first set of studies to further work in this area would be studies that clarify the meaning of clinical wisdom in therapists. These studies should include studying the perception of clinical wisdom from a client's perspective to see parallels and discrepancies. Another study could be designed to understand the differences and/or overlap with a therapist's perception of wise, effective, master, and ideal therapist.

The second set of studies would aim to take the correlates of clinical wisdom from this study to try to predict which behaviors actually contribute to therapists' self-perceived clinical wisdom. It would be an interesting next step to build a conceptual model of clinical wisdom and test that against the predictive model of correlates of self-perceived clinical wisdom in therapists. Another suggestion to further this work is to combine self-perceived clinical wisdom and self-perceived wisdom in close personal relationships to make a wisdom complex. Further research could be initiated to examine if that model of psychotherapist's self-perceived wisdom (clinical and in close personal relationships) approximates wisdom as seen in general population, and further study the correlates of this wisdom-complex in therapists.

To study clinical wisdom in therapists, a third set of studies could involve using scales to study wisdom in the general population (e.g., 3D-WS), in addition to the DPCCQ to compare their general wisdom with their domain specific clinical wisdom. This set of studies could be further extended to actually developing tools that could be applied to measure clinical wisdom in therapists.

Conclusion

The results of this study are partially consistent with literature that highlights the attributes of wise people in the general population. The correlates of therapists' self-perceptions of being wise with clients in this study involve effective practice and a sense of professional growth and development. The correlates which were not in line with the conceptual background of this research entail the lack of professional self-doubts and humility. Therapists, who perceive they are wise also perceived they had a larger set of clinical skills and qualities that enhanced not only the therapeutic relationship but also the technical work of therapeutic practice. In addition, the perception of being wise was associated with a sense of professional satisfaction and growth.

In terms of practitioner characteristics, the significant personal correlates of therapists who were feeling wise with clients were older age; partnered parents, separated or divorced parents; professed higher life satisfaction and lower stress; reported a higher level of emotional and psychological well-being; and perceived themselves as wise even in close personal relationships. The practitioner variables that were significantly associated with feeling wise with clients were more years of practice, an eclectic-integrative orientation, more years of training and supervision, experience of personal therapy as beneficial, and an enhanced perception of growing as a therapist. These results highlight that the benefits of growing toward feeling wise with clients is associated with both a sense of professional growth and satisfaction and a sense of psychological and emotional well-being personally. It would be essential to explore, through further research, why these self-perceived wise therapists in this study were not experiencing any professional self-doubts or seeking much external consultation when in difficulty.

Conversations around wisdom are becoming more prominent in the philosophy and business fields and in helping professions when speaking of skills that differentiate inspiring leaders from leaders who have a short-term vision of effectiveness or profits. The difference that most studies point to is an attitudinal difference that influences how knowledge, work, problems and even the business of living are experienced by wise people. It is an attitude that is seen to have long-term benefits for not only the person but for the world at large. In this study, a wise attitude influenced the practice and personal life of the therapists in a positive manner.

APPENDIX A

DPCCQ SUB-SCALES AND NUMBER OF ITEMS ASSOCIATED WITH EACH SCALE

DPCCQ SUB-SCALES AND NUMBER OF ITEMS ASSOCIATED WITH EACH SCALE

I. Identifying data: age; gender; nationality; date on which the DPCCQ was answered. (5 items)

II. Professional identification and background: didactic and supervisory experience; qualifications; affiliations; specialty training. (23 items)

III. Career level: practice duration; experience in specific settings; treatment modalities; types of client. (21 items)

IV. Overall development as a therapist: retrospective assessment of overall career development; initial orientation and skills; current skills; positive and negative influences on overall development. (51 items)

V. Experience of personal therapy: general attitude; personal history and experiences. (28 items)

VI. Orientation of therapeutic work: theories; ideal treatment goals; relational norms. (52 items)

VII. Current development as a therapist: assessment; feelings in recent sessions; influences on current development. (36 items)

VIII. Current practice: setting characteristics; treatment modalities; client characteristics. (43 items)

IX. Experiences of therapeutic work: difficulties; coping strategies; frame management and relational style; open questions regarding personal strengths and limitations. (96 items)

X. Personal characteristics: social and marital status; life satisfactions and stresses; aspects of emotional well-being; interpersonal style in close personal relationships (self-concept). (42 items)

Request the complete DPCCQ from David Orlinsky at the following email address: d-orlisnky@uchicago.edu.

APPENDIX B

RELEVANT PEER REVIEWED ARTICLES USING THE DPCCQ

(SELECTED COLLECTION)

RELEVANT PEER REVIEWED ARTICLES USING THE DPCCQ (Selected Collection)

1. Heinonen, E., Knekt, P., Jääskeläinen, T. &Lindfors, O. (2014). Therapists' professional and personal characteristics as predictors of outcome in long-term psychodynamic psychotherapy and psychoanalysis. *European Psychiatry*, *29*(5): 265–274.

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5. Seidler, K. P., Schreiber-Willnow, K., Hamacher-Erbguth, An., & Pfäfflin, M. (2003). Are body oriented psychotherapists unlike other psychotherapists? Therapeutic self-concept of therapists for Concentrative Movement Therapy (KBT). *Psychotherapeut*, *48*, 117–121.

6. Orlinsky, D. E. & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, DC, US: American Psychological Association.

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8. Smith, D. P. & Orlinsky, D. E. (2004). Religious and Spiritual Experience Among Psychotherapists. *Psychotherapy*, *41*(2), 144–151.

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APPENDIX C

ADDITIONAL ANALYSIS OF DATA FOR RESULTS

Correlation Between Self-Perceived Clinical Wisdom and Coping Skills

Coping Skills	**Correlations (Pearson's *r*)**
• Try to see the problem from a different perspective.	.128**
• Share your experience of the difficulty with your client.	.078**
• Seek some form of alternative satisfaction away from therapy.	.058**
• Make changes in your therapeutic contract with a client.	036*
• Just give yourself permission to experience difficult or disturbing feelings.	.055**
• See whether you and your client can deal with the difficulty together.	.080**
• Consult about the case with a more experienced therapist.	-.055**
• Sign up for a conference or workshop that might bear on the problem.	.071**
• Invite collaboration from a client's friends or relatives.	.032*
• Modify your therapeutic stance or approach with a client.	.076**

**Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Multiple Comparisons Using Scheffe Post Hoc Analysis to Study the Relationship of Self-Perceived Clinical Wisdom in Therapists and Therapist Nationality

Country	**Significantly higher (α = .01)means**	**Mean Difference**	**Significance**	**Significantly lower (α = .01)means**	**Mean Difference**	**Significance**
USA	UK	.297	< .001			
	Denmark	.278	< .001			
	Mexico	.573	< .001			
	Chile	.725	< .001			
	Australian	.464	< .001			
	Slovakia	.472	.002			
Canada	Chile	.641	< .001			
	Australia	.380	< .001			
UK	Chile	.428	< .001	USA	-.297	< .001
	Australia	.167	< .001	New Zealand	-.249	< .001
Denmark	Chile	.447	< .001	USA	-.278	< .001
Mexico				USA	-.573	< .001
				New Zealand	-.525	< .001

Country	Significantly higher (α = .01)means	Mean Difference	Significance	Significantly lower (α = .01)means	Mean Difference	Significance
Chile				USA	-.725	< .001
				Canada	-.641	< .001
				Malaysia	-.715	< .001
				New Zealand	-.676	< .001
				Turkey	-.792	.005
				Ireland	-.510	.003
Malaysia	Chile	.715	< .001			
	Australia	.454	< .001			
Australia				USA	-.010	< .001
				Canada	-.380	< .001
				UK	-.167	.007
				Malaysia	-.454	< .001
				New Zealand	-.416	< .001
NZ	Mexico	.525	.005			
	Chile	.676	< .001			

Country	Significantly higher (α = .01)means	Mean Difference	Significance	Significantly lower (α = .01)means	Mean Difference	Significance
	Australia	.416	< .001			
Turkey	Chile	.792	.005			
Ireland	Chile	.510	.003			
Slovakia				USA	-.472	.002

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VITA

Shveta Kumaria attained her Bachelor of Arts and Master of Arts degree from Indraprastha College, Delhi, India, majoring in Clinical Psychology. She continued her studies in the field of Clinical Psychology with a M. Phil. Degree from National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, India. After graduating, she entered the academe with teaching at Indraprastha College for women, Delhi, and established her own independent clinical practice.

Subsequently, Shveta moved on to work in the not-for-profit sector specifically developing and delivering training modules on identification, brief treatment, and referral of mental disorders in the State of Gujarat, India. In 2005 she helped set up the first international Employee Assistance Program (EAP) company, in Bangalore, India. She headed the India operations of the EAP Company for three years before changing direction to working with corporate clients. In the corporate sector she worked with leadership teams to move inspire them towards a more innovative mindset. Since, 2008 Shveta has been collaborating with Dr. Poornima Bhola in India, and Dr. David Orlinsky in Chicago to study therapist professional and personal development in India.

Shveta has presented in international and national conferences, and has written and published nationally, and internationally, on therapist factors in psychotherapy, psychotherapy integration, and financing of healthcare in the USA. In the fall of 2011, she entered the doctoral program at Loyola University Chicago, School of Social work. Since 2013, she has been

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Shveta will be joining The Family Institute at Northwestern University as a Post-Doctoral Clinical Fellow in Fall 2017.